

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |   |  |   |   |  |  |  |  |
|--|--|--|--|---|--|---|---|--|---|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |   |  |   |   |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |   |   |  |  |  |  |
| 14001  |  |  |  |   |  |   |   |  |   |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> COUNTY <b>Montgomery</b>                     |   |   |  |   |   |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |  |  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville, X</b>  |   |   |  |   |   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>14214 Briarwood Terrace</b>   |  |  |  |   | d. STREET ADDRESS<br><b>14214 Briarwood Terrace</b>  |   |   |  |   |   |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Woodley F. ABELL</b>   |  |  |  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>24</b> Year <b>1967</b>  |   |   |  |   |   |  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb 6th 1878</b>                           |   | 9. AGE (In years last birthday) <b>89</b>  |   |   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY      |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                     |   | 13. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |  |  |  |
| 13. FATHER'S NAME<br><b>Robert A. Abell</b>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Serena Hayden</b>   |   |   |  |   |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)   |  |  |  |   | 16. SOCIAL SECURITY NO.<br><b>578-22-7003</b>  |   |   |  |   | 17. INFORMANT<br>Address <b>Same as # 2</b> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>congestive heart failure</b><br><b>4201</b> DUE TO <b>Coronary arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |   |   |  |   |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>a.m.</b> p.m. <b>19</b>   |  |  |  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                |   |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10-3</b> <b>1967</b> to <b>10-24</b> , <b>1967</b> , that (I) (we) last saw the deceased alive on <b>10-12</b> , <b>1967</b> , and that death occurred at <b>12:30</b> PM, from the causes and on the date stated above.  |  |  |  |   |  |   |   |  |   |   |  |  |  |  |
| 22a. SIGNATURE<br><b>D. C. Bucy</b>  |  |  |  |   | M.D. <b>ABELL</b>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>10-24-67</b>                 |   |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>D. C. Bucy</b>  |  |  |  |   | 22d. ADDRESS<br><b>809 Veirs Mill Rd Rockville Md</b>  |   |   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>10-27-1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Wash, D.C.</b> |   |  |   |   |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Mattingly</b>   |  |  |  |   | ADDRESS<br><b>131 11th S.E. Wash 3, D.C.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>Oct 26 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. ...</b> |   |  |  |  |  |

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[illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

14000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14005

|   |                               |   |                                 |  |   |   |   |
|---|-------------------------------|---|---------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>  |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>  |                               | c. LENGTH OF STAY IN 1b<br><u>1/2 hr.</u>   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u> 15-1  |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Chapman Rd - Fawcett &amp; Haines Co.</u>  |                               |   |                                 | d. STREET ADDRESS<br><u>4506 Gaynor Rd.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ertel</u> Middle <u>E.</u> Last <u>Acker, Sr.</u>   |                               |   |                                 | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>26</u> Year <u>1967</u>  |   |   |   |
| 5. SEX<br><u>M.</u>   | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1907</u> |  | 9. AGE (In years lost birthday)<br><u>60</u> yrs. | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                 |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Machinist</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Printing</u>  |                                 | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Orville E. Aker</u>   |                               |   |                                 | 14. MOTHER'S MAIDEN NAME<br><u>Nannie B. Jackson</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u> <u>Air Force</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>579-03-7235</u>   |                                 | 17. INFORMANT<br>Address <u>Mildred E. Aker, wife, same item # 2</u>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction Acute.</u><br>DUE TO<br>(b) <u>Myocardial Infarction</u><br>DUE TO<br>(c) <u>Arterio Sclerosis Severe -</u>  |                               |   |                                 |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Recent</u><br><u>years.</u><br><u>years.</u>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               |   |                                 |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                 |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |                                 |  |   |   |   |
| ACTUAL SIGNATURE<br><u>John E. Ball</u> M.D.  |                               |   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/27/67.<br>Address (Street, city, town, or county) |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                               | 23b. DATE THEREOF<br><u>10-30-67</u>  |                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Rockville, Montg. Md.</u>                     |   |
| 24. FUNERAL DIRECTOR<br><u>Tyson Wheeler F. H., 1331 Rockville Pk. Rockville, Md.</u>   |                               |   |                                 | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 31 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |





## CERTIFICATE OF DEATH

14906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Filed in deep 2 - passed on by Med-Examiner

|  |                              |   |  |   |   |  |  |
|--|------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Mont</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Laurel</u>  |                              | c. LENGTH OF STAY IN 1b<br><u>54 years</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Laurel</u>                         |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>15701 RITCHESON LANE</u>  |                              |   |  | d. STREET ADDRESS<br><u>15701 RITCHESON LANE</u>  |   | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type of print)<br><u>J. AITCHESON</u> First Middle Last   |                              |   |  | 4. DATE OF DEATH<br><u>Oct 23</u> Month Day Year <u>1967</u>  |   |  |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 9, 1894</u> |   | 9. AGE (In years last birthday)<br><u>73</u> yrs. |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).<br><u>housewife</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>Joseph Jackson Suit</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ellen Geneva Beall</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>no</u>  |  | 17. INFORMANT<br><u>Catherine Hanson, Laurel Md</u> Address   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u><br>DUE TO<br>(b) <u>Coronary Atherosclerosis</u><br>DUE TO<br>(c) <u>Gen'l Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                              |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 HOUR</u><br><u>16 yrs</u><br><u>20 yrs</u>            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> , 19 <u>49</u> , to <u>10/23</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/20</u> , 19 <u>64</u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above.   |                              |   |  |   |   |  |  |
| 22a. SIGNATURE<br><u>J M Warren</u>  |                              |   |  | 22b. DATE SIGNED<br><u>10/23/67</u>   |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>J M WARREN</u>  |                              |   |  | 22d. ADDRESS<br><u>Laurel Md</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>10-26-67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Port Lincoln Cem</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Calmar Manor Md</u>                        |  |
| 24. FUNERAL DIRECTOR<br><u>De Witt Carson from Laurel, Md.</u>   |                              |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 30 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |

14.06

14.06



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14002

CERTIFICATE OF DEATH

14007

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>District of Columbia</b><br>b. COUNTY   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  | c. LENGTH OF STAY IN TB<br><b>11 years</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sylvan Manor Health Care Center</b>  |  | d. STREET ADDRESS<br><b>3039 Legation St., N. W.</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Elva</b> Middle <b>N.</b> Last <b>Allen</b>  |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>30</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Nov. 12, 1883</b>                                   |
| 9. AGE (In years last birthday)<br><b>83 yrs.</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>New Jersey</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |
| 13. FATHER'S NAME<br><b>Charles Ayres</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ada Laide Hammell</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  |
| 17. INFORMANT<br><b>Son</b><br>Address <b>Same as Item 2.</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Degeneration</b><br>DUE TO (b) <b>Cerebral Arterio-sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>October 1, 1967</b> , to <b>October 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>October 29, 1967</b> and that death occurred at <b>12:10 A.M.</b> from causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE<br><i>Robert T. Thibadeau</i>  |  | 22b. DATE SIGNED<br><b>October 30-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert T. Thibadeau</b>  |  | 22d. ADDRESS<br><b>11,000 Old Georgetown Road<br/>Rockville, Maryland 20852</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   | 23b. DATE THEREOF<br><b>10-30-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DATE NOV 1 1967</b>  |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |

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Nov. 11, 1902

Nov. 11, 1902

Nov. 11, 1902

Nov. 11, 1902

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CERTIFICATE OF DEATH

14008

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |   | c. LENGTH OF STAY IN TB<br><b>5 months</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Potomac Valley Nursing Home</b>   |   | e. STREET ADDRESS<br><b>6300 Poindexter Road</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>SARAH B. ALLMAN</b>  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>3</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 3, 1896</b>  |
| 9. AGE (In years last birthday)<br><b>71</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D. C.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>D. C.</b>  |   |
| 13. FATHER'S NAME<br><b>Robert E. Backham</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Eva Oliver</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Sister</b>   |   | Address<br><b>Mrs. Henry Latimer Same as Item 2.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO (b) <b>Acute Cardiac Failure</b><br>DUE TO (c) <b>Heart Block</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Adenocarcinoma of Uterus</b>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 19 58</b> to <b>10/3</b> , 1967, that (I) (not) last saw the deceased alive on <b>10/3</b> 1967, and that death occurred on <b>10/3</b> AM from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>Frank Y. Jagers Jr.</b>   |   | 22b. DATE SIGNED<br><b>10/4/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>FRANK Y. JAGGERS JR.</b>  |   | 22d. ADDRESS<br><b>5707 WISCONSIN AVE Bethesda, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>10-7-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>High Street Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Rocky Mount, Virginia</b> |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 9 1967</b>   |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14009

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>                      |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Dickerson</u>   |  | c LENGTH OF STAY IN 1b<br><u>20 yrs Rural Dickerson</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Route I. RFD.</u>  |  | d STREET ADDRESS<br><u>Route 1</u>   |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Carl Edwin ANDERSON</u>  |  | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>13</u> Year <u>1967</u>  |  |
| 5 SEX<br><u>WM</u>  | 6 COLOR OR RACE<br><u>W</u>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>07/11/00</u>   |
| 9 AGE (In years lost birthday) <u>67</u> yrs  |  | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____  |  |
| 10a US. AL OCC. PATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Carpenter Bldg.</u>  |  | 10b KIND OF BUSINESS OR INDUSTRY<br><u>Massachusetts</u>   |  |
| 11 BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>   |  | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13 FATHER'S NAME<br><u>John C. Anderson</u>   |  | 14 MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | 16 SOCIAL SECURITY NO<br><u>037 03-7516</u>  |  |
| 17 INFORMANT<br><u>Mrs. Marian Anderson Md R 500</u>  |  | Address <u>Dickerson</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hemorrhage Massive, Gastrointestinal</u><br>DUE TO<br>(b) <u>Esophageal Varices with Rupture</u><br>DUE TO<br>(c) <u>Cirrhosis, Liver</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)  |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19 _____  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e PLACE OF INJURY (Home form factory, street office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>John S. Ball</u> M.D.   |  | 22. DATE SIGNED <u>Oct. 13, 1967</u>   |  |
| EXAMINER'S NAME (Type)  |  | 22. DATE SIGNED  |  |
| 23a. BIRTH, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF  |  |
| <u>Burial</u>   |  | <u>10/16/67</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| <u>Monocacy</u>   |  | <u>Beallsville Montg. Md</u>   |  |
| 24 FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  |
| <u>Wm. B. Helton</u>  |  | <u>Barneville, Md</u>  |  |
| ADDRESS   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| <u>Barneville, Md</u>   |  | <u>Oct 17 1967</u>   |  |



CERTIFICATE OF DEATH

14010

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b><br>c. LENGTH OF STAY in 1b<br><b>3 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b><br>d. STREET ADDRESS<br><b>914 Philadelphia Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Evelyn (NMN) Anderson</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 27 19 67</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>6-19-07</b>   |
| 9. AGE (In years last birthday)<br><b>60 yrs.</b>  |  | 10. UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired clerk</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>C &amp; P Telephone Co</b>   |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Washington, D. C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>William E. Anderson</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mattie Lamb</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>577-01-1883</b>  |  |
| 17. INFORMANT<br><b>William L. Anderson</b>  |  | 13810 Congress Drive<br><b>Rockville, Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br>DUE TO 1. Thrombotic occlusion, left coronary artery<br>(b) 2. Acute anteroseptal myocardial infarction<br>(c) 3. Rupture of left ventricle.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/25/67</b> to <b>10/27/67</b> , that (I) (we) lost saw the deceased alive on <b>10/27</b> 19 <b>67</b> and that death occurred at <b>8:55 AM</b> , from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE<br><b>John J. Curry</b>   |  | 22b. DATE SIGNED<br><b>10/27/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John J. Curry</b>   |  | 22d. ADDRESS<br><b>10620 Georgia Ave Silver</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Oct. 31, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Port Lincoln Cemetery</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>Prince Georges Co., Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>NOV 2 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

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4005

14011

4005

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Mont</u>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>   |   | c. LENGTH OF STAY IN lb<br><u>2 yrs</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Corroll Hall Sanatorium</u>  |   | e. STREET ADDRESS<br><u>7011 Sycamore Ave</u>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>FREDERICK</u> Middle <u>C</u> Last <u>ANDERSON</u>   |   | DATE OF DEATH<br>Month <u>OCTOBER</u> Day <u>11</u> Year <u>1967</u>  |   |
| 5 SEX<br><u>Male</u>  | 6 COLOR OR RACE<br><u>White</u>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>NOV. 29, 1891</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired)<br><u>Accountant</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Railroad</u>  | 9. AGE (In years lost birthday)<br><u>75</u> yrs  |
| 11. BIRTH PLACE (County & State, or foreign country)<br><u>Washington, D.C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Christian Anderson</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Eckstein</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>yes</u> <u>W.W.I</u>  |   | 16. SOCIAL SECURITY NO<br><u>W.W.I</u>  |   |
| 17. INFORMANT<br><u>W.W.I</u>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GANGRENE OF LEFT FOOT</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.<br>(b) <u>GENERALIZED ARTERIO SCLEROSIS</u><br>DUE TO<br>(c) <u>DIABETES MELLITIS</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>CEREBRAL HEMORRHAGE</u>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 29, 1965</u> to <u>OCTOBER 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 11, 1967</u> , and that death occurred at <u>9:40 P.M.</u> from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><u>Henry Lowrey</u>   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                    | 22b. DATE SIGNED<br><u>OCTOBER 11, 1967</u>   |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION REMOVAL (Specify)  | 23b. DATE THEREOF<br><u>Oct 14-1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Congregational</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Rock - MD</u>                                 |
| 24. FUNERAL DIRECTOR<br><u>Northwest Funeral Home</u>   |   | 25a. REC'D BY REGISTRAR<br><u>Washington, D.C. 20012</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>Minister Judge</u>   |

DATE OCT 16 1967





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #8 Film #G393 10/18/67-7ph

CERTIFICATE OF DEATH

14012

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b><br>c. LENGTH OF STAY IN 1b<br><b>1809</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>Washington, D. C.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D. C.</b> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Henry E. Anderson</b><br>First Middle Last   |  | 4 DATE OF DEATH<br><b>Oct 11 1967</b><br>Month Day Year  |   |
| 5 SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>8/29/1886</b><br>9 AGE (In years last birthday) yrs.<br><b>81</b>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Printer- Retired</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Gov't</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Illinois</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Unobtainable</b>  |   |
| 13. FATHER'S NAME<br><b>Unobtainable</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unobtainable</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Unobtainable</b>   |  | 16. SOCIAL SECURITY NO.<br><b>577-64-4903</b>  |   |
| 17. INFORMANT<br><b>Miss Nell Lambert-2726 Conn. Ave. NW</b><br>Address  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b><br>DUE TO (b) <b>Cerebral Arteriosclerosis</b><br>DUE TO (c) <b>with senile psychosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>4 years</b>                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS A TOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> , to <b>Oct 11, 1967</b> , that (I) (we) lost saw the deceased alive on <b>Oct 9, 1967</b> , and that death occurred at <b>7:05 PM</b> , from causes and on the date stated above.  |  |  |   |
| 22a. SIGNATURE<br><b>Neil P. Campbell</b>  |  | 22b. DATE SIGNED<br><b>10/11/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Neil P. Campbell</b>  |  | 22d. ADDRESS<br><b>1629 Columbia Rd.</b>   |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10/14/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Congressional Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D. C.</b>                         |
| 24. FUNERAL DIRECTOR<br><b>The S.H. Hines Co. Washington, D. C.</b><br>ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 16 1967</b><br>DATE  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14913

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <b>Montgomery</b> MARYLAND   |                                 | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>                  |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |                                 | c LENGTH OF STAY IN IL<br><b>15</b>  |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>   |                                 | e STREET ADDRESS<br><b>8600 16th Street</b>  |  |
| 3 NAME OF DECEASED<br>(Type or print) <b>WALTER ARCH</b>  |                                 | 4 DATE OF DEATH<br>Month <b>Oct.</b> Day <b>8</b> Year <b>1967</b>   |  |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 AGE (In years and birthday)<br><b>65</b> |
| 9 UNDER 1 YEAR<br>Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min <b>15</b>   |                                 | 10 UNDER 24 HRS<br>Hours <b>15</b> Min <b>15</b>   |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Civil Engineer</b>   |                                 | 10b KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Gov.</b>  |  |
| 11 BIRTHPLACE (State or foreign country)<br><b>Pittsburgh, Pa.</b>  |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13 FATHER'S NAME<br><b>George Arch</b>  |                                 | 14 MOTHER'S MAIDEN NAME<br><b>Maria Bojorie</b>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                 | 16 SOCIAL SECURITY NO<br><b>Mary Arch - 8600 16th St., Sil. Sp., Md.</b>   |  |
| 17 INFORMANT<br><b>Mary Arch</b>  |                                 | 18 ADDRESS<br><b>8600 16th St., Sil. Sp., Md.</b>  |  |
| 19 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I DEATH WAS CAUSED BY<br><b>4201</b><br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>DUE TO<br>(b) <b>Coronary Artery Heart Disease</b><br>DUE TO<br>(c) <b>Coronary Artery Heart Disease</b>  |                                 | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |  |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b> p.m.   |                                 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)  |                                 | 20f (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |  |  |
| ACTUAL SIGNATURE <b>Belden R. Read</b> M.D.   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <b>BELDEN R. READ M.D.</b>   |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22. DATE SIGNED <b>Oct. 8, 1967</b>   |                                 | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                 | 23b DATE THEREOF<br><b>10/11/67</b>  |  |
| 23c NAME OF CEMETERY OR CREMATORY<br><b>Glade cem.</b>  |                                 | 23d LOCATION (City or Town) (County) (State)<br><b>Walkersville Fred. Md.</b>  |  |
| 24 FUNERAL DIRECTOR<br><b>H. C. Barton</b>  |                                 | 25a REC'D BY REG. STRAR<br><b>OCT 13 1967</b>  |  |
| 25b REG. STRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                 | 25c REG. STRAR'S SIGNATURE   |  |



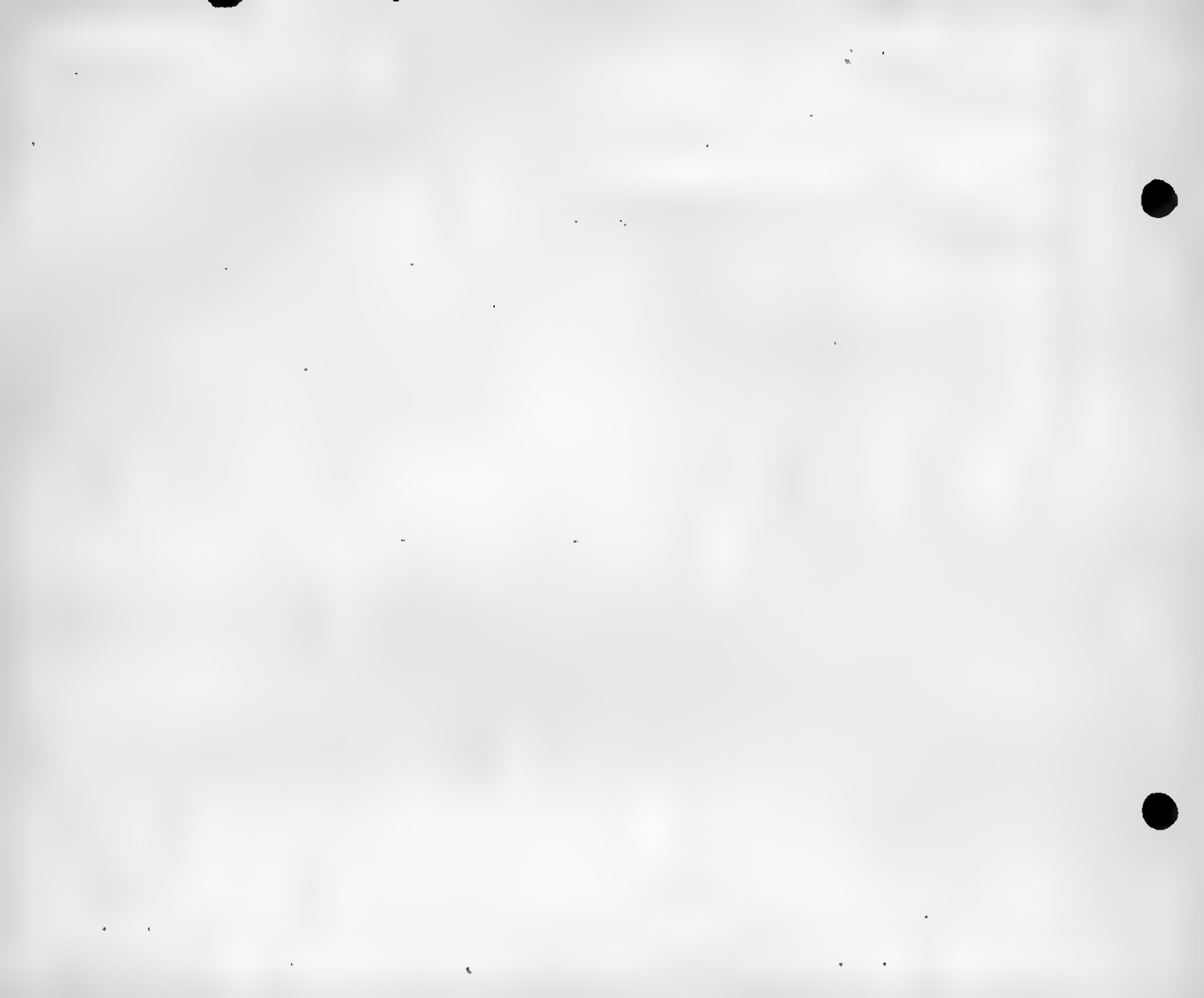
CERTIFICATE OF DEATH

1-1-1-1

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND   |                                     | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a STATE <u>Maryland</u> b COUNTY <u>Prince George</u>              |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |                                     | c LENGTH OF STAY IN IT<br><u>15 days</u>   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sent. &amp; Hospital</u>   |                                     | d STREET ADDRESS<br><u>8803 - 23rd Ave</u>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><u>Parke Alfred Arnold</u>   |                                     | 4 DATE OF DEATH<br>Month <u>10</u> Day <u>-31-</u> Year <u>1967</u>  |  |
| 5 SEX<br><u>Male</u>  | 6 COLOR OR RACE<br><u>Caucasian</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>April 1, 1902</u>                                  |
| 9 AGE (in years last birthday)<br><u>65 yrs</u>   |                                     | 10 IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>31</u> Hours <u>19</u> Min <u>67</u>  |  |
| 11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Govt Employee</u>  |                                     | 11b KIND OF BUSINESS OR INDUSTRY<br><u>New York</u>  |  |
| 12 BIRTHPLACE (County & State, or foreign country)<br><u>U.S.A.</u>   |                                     | 13 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 14 FATHER'S NAME<br><u>Alfred Arnold</u>  |                                     | 15 MOTHER'S MAIDEN NAME<br><u>Minnee Reeder</u>  |  |
| 16 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u>   |                                     | 17 SOCIAL SECURITY NO.<br><u>?</u>   |  |
| 18 INFORMANT (Mrs. Nellie Arnold) Address<br><u>wife 8803 - 23rd Ave Adelphi, Md</u>  |                                     |  |  |
| 19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolism R. lung.</u><br>DUE TO <u>chronic phlebitis left leg -</u><br>DUE TO <u>chronic nephrosclerosis</u>                |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><u>5-10 minutes</u><br><u>1 year</u><br><u>3-4 yrs.</u>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Generalized arteriosclerosis &amp; myeloma</u>   |                                     | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |                                     | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u></u>   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour <u>am</u> <u>19</u> p.m.  |                                     | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u>  |                                     | 20f (City or town) (County) (State)<br><u></u>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>November, 1941</u> to <u>10/31/1967</u> , that (I) (we) last saw the deceased alive on <u>10-31-1967</u> , and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above. |                                     |  |  |
| 22a SIGNATURE<br><u>N.C. Shoemaker M.D.</u>   |                                     | 22b DATE SIGNED<br><u>11-1-67</u>  |  |
| 22c PHYSICIAN'S NAME (Type)<br><u>N.C. Shoemaker M.D.</u>   |                                     | 22d ADDRESS<br><u>811 Dale Drive Silver Spring, Md</u>   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b DATE THEREOF<br><u>11/3/67</u>  | 23c NAME OF CEMETERY OR CREMATORY<br><u>Glenwood Cemetery</u>  | 23d LOCATION (City or Town) (County) (State)<br><u>Washington, D. C.</u> |
| 24 FUNERAL DIRECTOR<br><u>The S. H. Hines Company - Washington, DC</u>  |                                     | 25a REC'D BY REGISTRAR<br><u>NOV 3 1967</u>  |  |
|   |                                     | 25b REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral director's page 2 and return it to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MEDICAL CERTIFICATION  
Cleared by medical examiner

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |   |  |
| 4013  |  |   |  |  |  |  |  |  |  |   |  |
| 14015   |  |   |  |  |  |  |  |  |  |   |  |
| 1 PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i><br>c. LENGTH OF STAY IN 1b<br><i>Silver Spring</i><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hosp.</i> |  |   |  |  |  | 2 USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission)<br>a. STATE <i>Maryland</i><br>b. COUNTY <i>Montgomery</i><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i><br>d. STREET ADDRESS <i>10610 Mantz Road</i><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| 3 NAME OF DECEASED (Type or print)<br>First <i>Gerald</i> Middle <i>E.</i> Last <i>Ashour</i>   |  |   |  |  |  | 4 DATE OF DEATH<br>Month <i>10</i> Day <i>14</i> Year <i>1967</i>  |  |  |  |   |  |
| 5 SEX <i>Male</i>   |  | 6 COLOR OR RACE <i>White</i>                        |  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br><i>11-20-01</i>   |  | 9 AGE (In years last birthday) <i>65</i> yrs                   |  | 10 IF UNDER 1 YEAR<br>Months <i>14</i> Days <i>19</i> Hours <i>67</i> Min.                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker-Ret. Wendor Bread</i>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Iowa</i>  |  |  |  | 11 BIRTHPLACE (County & State, or foreign country) <i>Iowa</i> |  |   |  |
| 13 FATHER'S NAME <i>Theodore Ashour</i>   |  |   |  |  |  | 14 MOTHER'S MAIDEN NAME <i>Mary Angel</i>  |  |  |  |   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>  |  |   |  | 16 SOCIAL SECURITY NO. <i>495 03 1632</i>  |  | 17 INFORMANT <i>Holy Cross Hospital 1500 Forest Glen</i>   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cerebral anoxia</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Cerebral hemorrhage</i><br>DUE TO<br>(c)  |  |   |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>14 days</i>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>Diabetes Mellitus</i>  |  |   |  |  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (F EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <i>19</i> o.m. p.m.  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |  | 20f. (City or town) (County) (State)                           |  | 19 WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1, 1967</i> , to <i>Oct 14, 1967</i> , that (I) (we) last saw the deceased alive on <i>Oct 13 1967</i> , and that death occurred at <i>6 AM</i> , from causes and on the date stated above.  |  |   |  |  |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><i>Edward J. Richards</i>   |  |   |  |  |  | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>   |  | 22b. DATE SIGNED<br><i>10-14-67</i>                            |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>Edward J. Richards</i>   |  |   |  |  |  | 22d. ADDRESS   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE THEREOF<br><i>10/17/67</i>                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Wheaton - Mont. Md.</i>  |  | 25a. REC'D BY REGISTRAR<br><i>W.W. Chambers</i>                |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>W.W. Chambers</i>  |  | 25b. REG. STRAR'S SIGNATURE<br><i>W.W. Chambers</i> |  | 25c. DATE<br><i>OCT 18 1967</i>  |  | 25d. REG. STRAR'S SIGNATURE<br><i>W.W. Chambers</i>  |  |  |  |   |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <u>M.D.</u> b. COUNTY <u>Montgomery</u>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>   |   | c. LENGTH OF STAY IN 1b <u>DO A.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SANITARIUM</u>  |   | d. STREET ADDRESS <u>1303 ELSON</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>THEODORE THOMAS AYERS</u>  |   | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>13</u> Year <u>1967</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-4-1900</u>   |
| 9. AGE (In years last birthday) <u>67</u> yrs   |   | F UNDER 1 YEAR<br>Months Days   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Pathologist</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>  |  |
| 13. FATHER'S NAME <u>JOHN D.P. AYERS</u>  |   | 14. MOTHER'S MAIDEN NAME <u>HEIZER</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>  |   | 16. SOCIAL SECURITY NO <u>215-44-8267</u>   |  |
| 17. INFORMANT <u>Mrs. Ethel Ayers</u>   |   | Address <u>1303 Elson Court, Takoma Park, D.C.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u><br>DUE TO<br>(b) <u>Coronary artery atherosclerosis</u><br>DUE TO<br>(c) <u>last.</u>   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>   |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.   |   | 22. DATE SIGNED <u>10/13/1967</u>   |  |
| EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>   |   | Address (If not in city or county)  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF <u>Oct. 16, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u> |
| 24. FUNERAL DIRECTOR <u>James E. Humphrey, Inc.</u>   | Address <u>Silver Spring, Md.</u>   | 25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                              |



## CERTIFICATE OF DEATH

14017

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>o. STATE <b>Florida</b><br>b. COUNTY                               |   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Bethesda (rural)</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jacksonville</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>  |  | d. STREET ADDRESS<br><b>4544 Harlow Blvd.</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Betty</b> Middle <b>Faye</b> Last <b>BALLARD</b>  |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>17</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Cauc</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 15, 1941</b>   |
| 9. AGE (In years last birthday)<br><b>26 yrs</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min <b>26</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>H-Wife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Florida</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>William Augustus Barker</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Bessie Louise Waters</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>UNKNOWN</b>   |  | 16. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>   |   |
| 17. INFORMANT <b>Panasoffke, Florida</b><br><b>Mrs. Rufus Adams, P.O. Box 175, Lake</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>HEMORRHAGE, CAROTID ARTERY, RIGHT</b><br>DUE TO<br>(b) <b>RHABDOMYOSARCOMA, RIGHT TONSIL</b><br>DUE TO<br>(c) <b>1450</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.          |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 24</b> , 19 <b>67</b> , to <b>Oct. 17</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 17</b> , 19 <b>67</b> , and that death occurred at <b>4:15 PM</b> , from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><b>G. W. Taylor, M.D.</b>  |  | 22b. DATE SIGNED<br><b>Oct. 19, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>G. W. TAYLOR, M. D.</b>  |  | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><b>10/20/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town) (County) (State)<br><b>Jacksonville, Fla.</b>                        |
| 24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b> ADDRESS<br><b>1400 Chapin Street, N.W. Washington, D. C.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>OCT 24 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MONTGOMERY COUNTY, MARYLAND   |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  |  |  |  |
| a. COUNTY <b>Montgomery</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>           |  | a. STATE <b>Maryland</b>   |  | b. COUNTY <b>Montgomery</b>  |  |
| c. LENGTH OF STAY IN 1b <b>11 mos. 28 days 16 hrs</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>         |  | d. STREET ADDRESS <b>8303 Navahoe Dr.</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>  |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Fra Russell Barden</b>   |  |   |  | 4. DATE OF DEATH <b>October 24, 1967</b>   |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>6-25-21</b>  |  |
| 9. AGE (in years last birthday) <b>46</b>   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Const.</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>                                 |  |
| 13. FATHER'S NAME <b>Jesse Barden</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, or unknown) <b>NO</b>   |  |   |  | 16. SOCIAL SECURITY NO <b>226-1-6085</b>   |  | 17. INFORMANT <b>Hospital Records</b> Address <b>7600 Carroll Ave.</b>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY   |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <b>Multiple myeloma</b>   |  |   |  |  |  |  |  |
| DUE TO  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |  |  |  |  |
| (b) DUE TO  |  |   |  |  |  |  |  |
| (c)   |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-5-2</b> , 19 to <b>10-24</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>10-23</b> , 19 <b>67</b> , and that death occurred at <b>4:30</b> AM, from causes and on the date stated above |  |   |  |  |  |  |  |
| 22a. SIGNATURE <b>M. Snow MD</b>  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <b>Oct. 24, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>M. Snow, MD.</b>  |  |   |  | 22d. ADDRESS <b>2013 W. Ave. Silver Spring, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF <b>Oct. 26, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Md.</b>                         |  |
| 24. FUNERAL DIRECTOR <b>John Thomas</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>Charles Judge</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |
| 25c. ADDRESS <b>2013 W. Ave. Silver Spring, Md.</b>   |  |   |  | DATE <b>OCT 27 1967</b>  |  |  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14019

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> COUNTY <b>PRINCE GEORGE'S</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LAUREL</b>   |   |
| c. LENGTH OF STAY IN 1b<br><b>10 Days</b>   |  |   |   |
| a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>HOLY CROSS HOSPITAL OF SILVER SPRING</b>   |  | d. STREET ADDRESS<br><b>824 8th Street</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>HELEN</b>   |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>8</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Caucasian</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/5/38</b>   |
| 9. AGE (in years lost birthday)<br><b>29 yrs</b>  |  | 10. FUNDING 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>IRVING JOHNSON</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>PEGGY BRYANT</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO  |  | 17. INFORMANT<br><b>R.D. BLANKENSHIP - 824-8th St LAUREL Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute and old coronary thrombosis</b><br>DUE TO<br>(b) <b>Coronary artery heart disease, severe</b><br>DUE TO<br>(c) <b>lost.</b>   |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, c.   |  | 19. WAS AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b> M.D.  |  | 22. DATE SIGNED<br><b>OCT. 8, 1967</b>  |   |
| EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP M.D.</b>  |  | 23. DEPUTY MEDICAL EXAMINER<br><b>Charles Judge</b> (City or County)  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><b>OCT 11, 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>UNION CEMETERY</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BURTONSVILLE MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>Charles Judge</b>  |  | 25. REC'D BY REG. STRAR<br><b>OCT 10 1967</b>   |   |
| 26. REC'D BY REG. STRAR'S SIGNATURE<br><b>Charles Judge</b>   |  | 27. REC'D BY REG. STRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |



14020

## CERTIFICATE OF DEATH

4015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick</u>   |  | d. STREET ADDRESS <u>12016 - Clarendon Rd.</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Robert T. Barrett</u>   |  | DATE OF DEATH <u>Oct. 2</u> 19 <u>67</u>  |  |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/22/17</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>physician</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>  | 9. AGE (In years last birthday) <u>50</u> yrs  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Robert T. Barrett</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Teresa C. Webb</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>yes. W.W.II</u>   |  | 16. SOCIAL SECURITY NO. <u>49205 E. Barrett</u>   |  |
| 17. INFORMANT <u>James</u>  |  | Address <u>Bethesda</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis and thrombosis</u><br>DUE TO<br>(c) <u>3 weeks</u> |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-24</u> , 19 <u>67</u> , to <u>10-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-2</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M., from causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <u>W. F. Joyce</u>   | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | 22b. DATE SIGNED <u>10-3-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>W. F. JOYCE</u>   | 22d. ADDRESS <u>4977 Battery lane, Bethesda, Md.</u>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>10-5-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>                   |
| 24. FUNERAL DIRECTOR <u>F. J. Collins</u>   | ADDRESS <u>Wash. D.C.</u>  | 25a. REC'D BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>   |
| FRANCIS J. COLLINS 3821 14TH. ST. N.W.  |  | DATE <u>OCT 5 1967</u>  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |  |  |   |  |   |  |   |  |
|---|--|------------------------------|--|--|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |  |  |   |  |   |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                              |  |  |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  |                              |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |  |                              |  | c. LENGTH OF STAY IN 1b<br><b>11 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>UNIVERSITY NURSING HOME Bethesda</b>                   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>HOLY CROSS HOSPITAL</b>  |  |                              |  |  |  | d. STREET ADDRESS <b>5300 Westbroad Ave.</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>HENRIETTA</b> First Middle Last   |  |                              |  |  |  | 4. DATE OF DEATH<br><b>Oct. 7 19 67</b> Month Day Year  |  |   |  |   |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>W</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>BEB. 15, 1887</b>  |  | 9. AGE (In years lost birthday) yrs <b>80</b> |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |                              |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>NEW YORK, USA</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Harris Cohen</b>  |  |                              |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Silvia</b>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)  |  |                              |  | 16. SOC. SEC. SECURITY NO.   |  | 17. INFORMANT<br><b>Mrs. Silvia Vogel- 1900 Lyttonsville Rd.</b>  |  |   |  | Address <b>Silver Spg. Md</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>260 X</b> IMMEDIATE CAUSE (a) <b>Bilateral lobar pneumonia,</b><br>DUE TO<br>Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Coronary artery heart disease</b><br>DUE TO (c) <b>Diabetes Mellitus</b>   |  |                              |  |  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>260 X</b>  |  |                              |  |  |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                              |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                              |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)          |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                              |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.   |  |                              |  |  |  | 22. DATE SIGNED <b>Oct. 7, 1967</b>   |  |   |  |   |  |
| EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>   |  |                              |  |  |  | DEPUTY MEDICAL EXAMINER (Type) <b>Charles J. J...</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify)<br><b>Burial</b>   |  |                              |  | 23b. DATE THEREOF<br><b>Oct. 9, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King David Mem. Garden Falls Church, Va.</b>   |  | 23d. LOCATION (City or Town) (County) (State) |  | 25a. RECEIVED BY REGISTRAR<br><b>Oct 11 1967</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Bernard Danzansky &amp; Sons</b><br>3501 14th. Street, N.W.; Wash., D.C.   |  |                              |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>  |  |   |  |   |  |





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14-22

|  |                              |   |                                |
|--|------------------------------|---|--------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                              | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                |
| b. CITY OR TOWN (If outside corporate limits, write F.R.A. and give nearest town) <u>Bethesda</u>  |                              | c. CITY OR TOWN (If outside corporate limits, write R.J.R.A. and give nearest town) <u>Poolesville</u>  |                                |
| c. LENGTH OF STAY IN 1b <u>2 hrs. 3 min</u>  |                              | d. STREET ADDRESS <u>Box 153</u>  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>  |                              | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                |
| 3 NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wilson</u> Last <u>Beall</u>   |                              | 4 DATE OF DEATH Month <u>Oct.</u> Day <u>11</u> Year <u>1967</u>  |                                |
| 5 SEX <u>male</u>  | 6 COLOR OR RACE <u>white</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>9-11-42</u> |
| 9 AGE (in years lost birthday) <u>25</u> yrs   |                              | FUND 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>16</u> Min <u>67</u>   |                                |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck DRIVER</u>   |                              | 10b KIND OF BUSINESS OR INDUSTRY <u>Montgomery Roads Dept. Maryland</u>   |                                |
| 11 BIRTHPLACE (State or foreign country) <u>Maryland</u>   |                              | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                |
| 13 FATHER'S NAME <u>MARION WILSON BEALL</u>  |                              | 14 MOTHER'S MAIDEN NAME <u>RUTHER</u>   |                                |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>  |                              | 16 SOCIAL SECURITY NO <u>216-40-6191</u>  |                                |
| 17 INFORMANT <u>add same as address.</u>   |                              | 18 DATE OF DEATH <u>10-11-67</u>  |                                |
| 19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Injuries, multiple and severe</u><br>DUE TO<br>(b) <u>secondary to automobile accident</u><br>DUE TO<br>(c) <u>last</u>  |                              | INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>   |                                |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                              | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Passenger in car that crashed into utility pole</u>        |                                |
| 20c TIME OF INJURY Month, Day, Year <u>12:30 a.m. 10/11/1967</u>   |                              | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work  |                                |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>   |                              | 20f (City or town) <u>Wheaton</u> (County) <u>Montgomery</u> (State) <u>Md.</u>   |                                |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |                                |
| ACTUAL SIGNATURE <u>John S. Ball</u> M.D.  |                              | 22 DATE SIGNED <u>10/11/67</u>  |                                |
| EXAMINER'S NAME (Type) <u>John S. Ball</u>   |                              | 23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>  |                                |
| 23b DATE THEREOF <u>Oct 13-67</u>  |                              | 23c NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>   |                                |
| 23d LOCATION (City or town) <u>Beallsville</u> (County) <u>Montgomery</u> (State) <u>Md.</u>   |                              | 25a REC'D BY REGISTRAR <u>Charles Judge</u>   |                                |
| 24 FUNERAL DIRECTOR <u>William B. Hilton, Barnesville, Md.</u>   |                              | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                                |
| DATE <u>OCT 16 1967</u>  |                              |   |                                |



CERTIFICATE OF DEATH

14023

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |   |
| c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>  |   | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | a. STREET ADDRESS <u>205-71 Adams St.</u>  |   |
| 3. NAME OF DECEASED (Type or print) <u>Florence Emily Beall</u>  |   | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1967</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/26/1882</u>                                     |
| 9. AGE (In years, last birthday) <u>85</u> yrs   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>   | 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>                              |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>   | 13. FATHER'S NAME <u>GEORGE W. YNGLESBEE</u>  |  | 14. MOTHER'S MAIDEN NAME <u>ANNIE C. HEIMS</u>                        |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  | 16. SOCIAL SECURITY NO. <u>217-05-7313</u>  | 17. INFORMANT Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO <u>4201</u><br>(b) <u>Arteriosclerosis</u><br>DUE TO <u>Arteriosclerosis</u><br>(c) <u>Arteriosclerosis</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>16 hr - 30 yr</u>                 |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>1967</u> , that (I) (we) lost saw the deceased alive on <u>1967</u> , and that death occurred at <u>11 A</u> M. from causes and on the date stated above.                                    |   |  |   |
| 22a. SIGNATURE <u>W. S. Murphy</u>   |   | 22b. DATE SIGNED <u>10-23-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>W. S. Murphy</u>   |   | 22d. ADDRESS <u>615 W. Montgomery Ave. Rockville, Maryland</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>10-26-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Goshen Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Goshen, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |   | 25a. REC'D BY REGISTRAR <u>OCT 26 1967</u>   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14021

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Pr</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park, Md.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hyattsville</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanatorium &amp; Hospital</u>  |  | d. STREET ADDRESS<br><u>2415 Chipman Rd.</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Joseph Dalridge Beavers</u>   |  | 4. DATE OF DEATH <u>Oct. 2 1967</u>  |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 6 - 1920</u>   |
| 9. AGE (In years last birthday) <u>47 yrs</u>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Self</u>  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Washington, D.C.</u>            |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 13. FATHER'S NAME <u>SAMUEL Beavers</u>  |   |
| 14. MOTHER'S MAIDEN NAME <u>Eva. Skinner</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>yes</u>                                    |   |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><u>Medical Records</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u><br><u>153.8</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Generalized carcinomatous</u> DUE TO<br>(c) <u>carcinoma colon</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>78 hours</u><br><u>18 months</u><br><u>4 years</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>10/2</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/2</u> 1967, and that death occurred at <u>12:30</u> P.M. from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE <u>HUGH W. IREY</u>   |  | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>HUGH W. IREY</u>   |  | 22d. ADDRESS <u>7105 Riggs Rd. Hyattsville, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>   | 23b. DATE THEREOF<br><u>10/5/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln Cemetery Prince Georges County, Md.</u>   | 23d. LOCATION (City or Town) (County) (State)   |
| 24. FUNERAL DIRECTOR<br><u>Sh. S. Hines &amp; 2901-14th St.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>OCT 4 1967</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14025

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Florida</u> b. COUNTY                                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sarasota</u>   |  |
| c. LENGTH OF STAY IN 1b<br><u>266 days</u>  |   | d. STREET ADDRESS<br><u>1424 4th Street</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Orville</u> Middle <u>John</u> Last <u>Beemer</u>  |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>9</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>11 August 1916</u>                        |
| 9. AGE (In years last birthday)<br><u>51</u> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Writer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>--</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ohio</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>John Beemer</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Lola Mae Biker</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>299-05-1602</u>  |  |
| 17. INFORMANT<br><u>The Medical Record</u><br><u>The Clinical Center, Bethesda, Maryland</u>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Rupture of Left Carotid Artery</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Recurrent Squamous Cell Carcinoma of Neck with</u><br>DUE TO <u>Erosion of Carotid Artery</u><br>(c) <u>  </u> |   |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>1 Year</u>  |   |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                             |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 16, 1967</u> , to <u>Oct. 9, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 9, 1967</u> , and that death occurred at <u>11:45M</u> , from causes and on the date stated above  |   |   |  |
| 22a. SIGNATURE<br><u>Jean B. de Kernion</u>   |   | 22b. DATE SIGNED<br>P.M. <u>11 October 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Jean B. de Kernion, M. D.</u>  |   | 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><u>10-18-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Daunton</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Maryland</u> |
| 24. FUNERAL DIRECTOR<br><u>Araguez</u>  |   | 25a. REC'D BY REGISTRAR<br><u>OCT 20 1967</u>   |  |
| ADDRESS<br><u>389 Rhode Island</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>  |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

14021

14026

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |   |  |
|--|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |   | c. LENGTH OF STAY IN IT<br><b>Washington DC</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>   |   | e. STREET ADDRESS<br><b>1717 Juniper St NW</b>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Bengis</b> Last <b>Bengis</b>  |   | 4 DATE OF DEATH<br>Month <b>10</b> Day <b>8</b> Year <b>1967</b>  |  |
| 5 SEX<br><b>male</b>   | 6 COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. AGE (In years lost birthday)<br><b>77</b> yrs |
| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Chemist</b>  |   | 10. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>CONNECTICUT</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Morris Bengis</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Katherine</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>N/A</b>  |   | 16. SOCIAL SECURITY NO<br><b>049-01-4364</b>  |  |
| 17. INFORMANT<br><b>Dorothy Bengis</b>   |   | Address<br><b>Item # 2</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>DUE TO (b) <b>Coronary Artery Heart Disease</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month Day Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   | 20f. (City or town) (County) (State)             |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP, M.D.</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 22. DATE SIGNED<br><b>Oct. 8, 1967</b>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, or REMOVAL (Type)<br><b>Cremation</b>  |   | 23b. DATE THEREOF<br><b>10/9/67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>  |   | 23d. LOCATION (City or town) (County) (State)<br><b>Suitland Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler Sons Inc.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 10 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   | ADDRESS<br><b>5130 Wisconsin Ave NW Washington, D.C.</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Laurel</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington San &amp; Hospital</b>  |                                  | d. STREET ADDRESS<br><b>350 Cokeland St.</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Jodi</b> Middle <b>Lynn</b> Last <b>Berger</b>   |                                  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>1</b> Year <b>67</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 1, 1967</b> |
| 9. AGE (In years lost birthday) yrs<br><b>—</b>   |                                  | IF UNDER 1 YEAR<br>Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>5</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Montgomery Co., Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Richard Eugene Berger</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Patricia Ann Wess</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><b>Richard Berger</b>  |                                  | Address<br><b>Laurel, Maryland</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>7700</b> IMMEDIATE CAUSE (a) <b>Hypoxia Fetalis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Rh - HI sensitization</b><br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.  |                                  |   |   |
| 22a. SIGNATURE<br><b>N. Stoehr</b>  |                                  | 22b. DATE SIGNED<br><b>10-1-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>N. Stoehr, M.D.,</b>  |                                  | 22d. ADDRESS<br><b>831 University Blvd., E., Silver Spring</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 23b. DATE THEREOF<br><b>10-2-67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington San &amp; Hospital</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Takoma Park, Montg., Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>J.D. Ruffcorn, 7600</b>  |                                  | ADDRESS<br><b>Carroll Ave., Takoma Park, Md.</b>  |   |
| 25a. REC'D BY REGISTRAR<br><b>Oct 4 1967</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14028

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. LENGTH OF STAY IN 1b <u>LOA</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |  | d. STREET ADDRESS <u>8516 Fox Run</u>   |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Julian Lawrence Bernstein</u>  |  | 4 DATE OF DEATH <u>October 3 1967</u>   |  |
| 5 SEX <u>male</u>   | 6 COLOR OR RACE <u>white</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 18-1920</u>  |
| 9 AGE (n years last birthday) <u>46</u> yrs   |  | 10. UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DIR. OF EDUCATION</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRONICS ENGR.</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>M.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>HERMAN BERNSTEIN</u>   |  | 14. MOTHER'S MAIDEN NAME <u>CHARLOTTE GLUCKSTEIN</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>   |  | 16. SOC. A. SECURITY NO. <u>121-07-4601</u>   |  |
| 17. INFORMANT <u>JOAN BERNSTEIN</u> Address <u>(same as above)</u>  |  |   |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>4201 DUE TO <u>Coronary arteriosclerosis with occlusion</u><br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>DUE TO _____   |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <u>John E. Bell</u> M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/4/67</u>  |  |
|   |  | Address (Street, city, town, or county)   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 23b. DATE THEREOF <u>10/8/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>MT. AARAT Cem.</u>  | 23d. LOCATION (City or Town) (County) (State) <u>FARMINGDALE, L.I., N.Y.</u>                   |
| 24. FUNERAL DIRECTOR <u>Greengard Funeral Home</u>  |  | 25a. REC'D BY REGISTRAR <u>1967</u>   |  |
| ADDRESS <u>4217 9th St. NW</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |



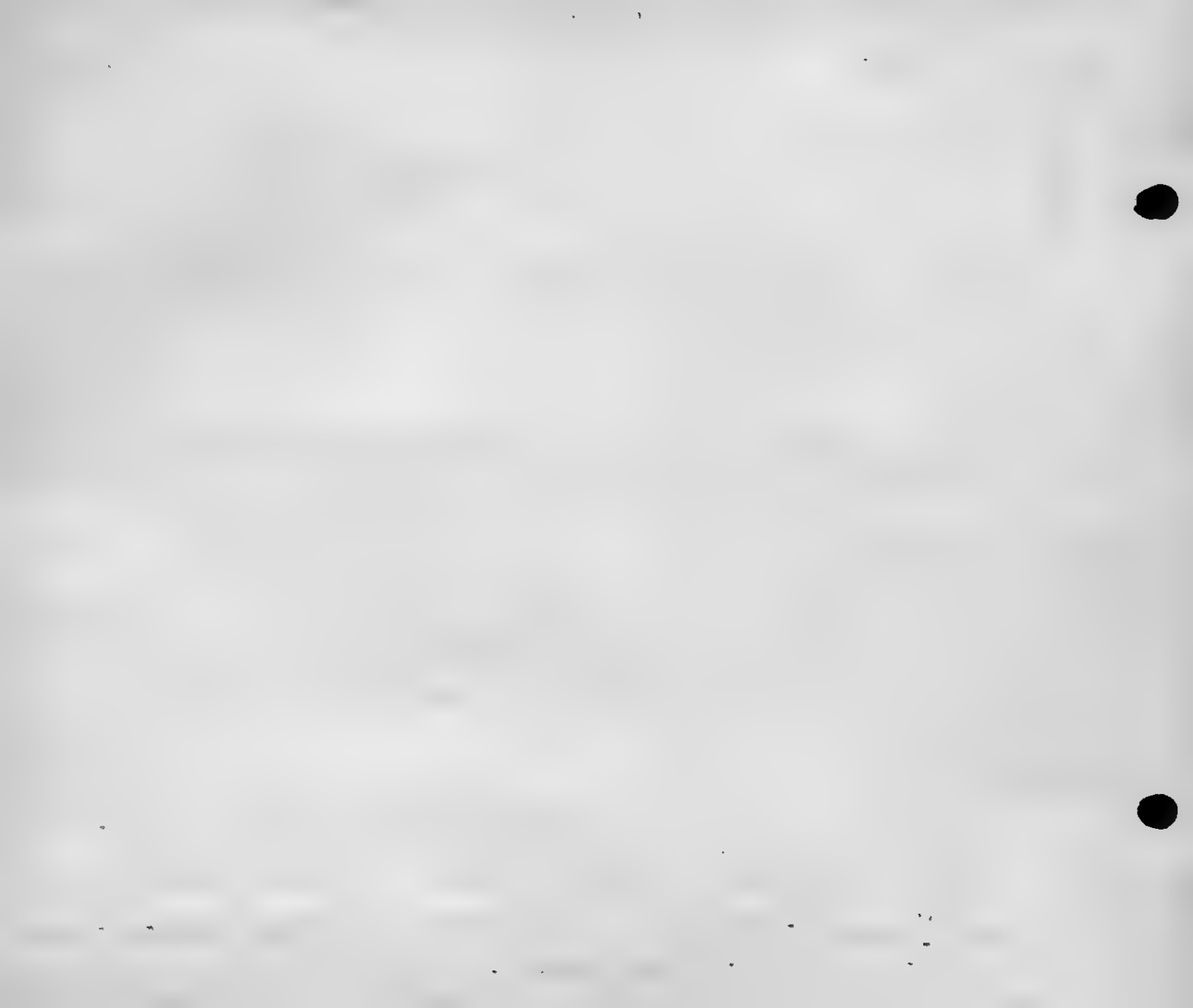
CERTIFICATE OF DEATH

14029

4024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u><br>c. LENGTH OF STAY IN 1b <u>9 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nsg Home 2101 Fairland Rd Silver Sp. Md. 20904</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>11919 Old Columbia Pike</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>John Virginia Berry</u><br>5. SEX <u>female</u><br>6. COLOR OR RACE <u>white</u><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <u>8 Oct 1888</u><br>9. AGE (in years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  | <b>4. DATE OF DEATH</b> <u>10 29 1967</u><br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sup. housekeeper</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>private home</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>Edgehill, Virginia</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| <b>13. FATHER'S NAME</b> <u>Wesley Berry</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>Yes</u><br><b>17. INFORMANT</b> <u>Rose Latvia Adm - RN</u> Address <u>2101 Fairland Rd Silver Sp. Md. 20904</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Dora Rollin</u><br><b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous generalized</u><br>(b) <u>Carcinoma</u><br>(c) <u>metastases</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>Severe Arteriosclerosis</u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u><br>Hour e.m. <u>157X</u> p.m.<br><b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |  | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/1/1967</u> <b>to</b> <u>10/29/1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>10/29/1967</u> <b>and that death occurred at</b> <u>10 A.M.</u> <b>from the causes and on the date stated above.</b><br><b>22a. SIGNATURE</b> <u>J M Warren</u> <b>22b. DATE SIGNED</b> <u>Oct. 29, 1967</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>J M Warren</u> <b>22d. ADDRESS</b> <u>Laurel Md</u><br><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Nov. 1, 1967</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u> <b>23d. LOCATION (City, town or county)</b> <u>Prince Georges Co. Md.</u> (State) |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey, Inc.</u> <b>25. REC'D BY REGISTRAR</b> <u>NOV 1 1967</u> <b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u><br>Address <u>8434 Georgia Avenue Silver Spring, Md.</u>   |  |  |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14025

## CERTIFICATE OF DEATH

1430

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |   | c. LENGTH OF STAY IN 1b<br><b>D. O. A.</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>   |   | d. STREET ADDRESS<br><b>3515 Farthing Drive</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>VERNE RUBEN BERTSCH</b>   |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>25</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/25/25</b>  |
| 9. AGE (In years last birthday)<br><b>42</b> yrs   |   | 10. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nat. Pk. Serv.</b>  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>U. S.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |   |
| 13. FATHER'S NAME<br><b>Otto Bertsch</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Edna Schmidt</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes</b>  |   | 16. SOCIAL SECURITY NO.<br><b>501-12-7022</b>   |   |
| 17. INFORMANT<br><b>Barbara Bertsch</b>  |   | Address <b>Wheaton, Md.</b><br><b>3515 Farthing Dr.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>arteriosclerotic heart disease</b><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b>  |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>none</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>11</b> a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) this hospital attended the deceased from <b>July</b> , 19 <b>67</b> to <b>25 Oct</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July</b> , 19 <b>67</b> , and that death occurred at <b>5A</b> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>Paul J. Moore</b>   |   | 22b. DATE SIGNED<br><b>Oct 25, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Paul J. Moore</b>   |   | 22d. ADDRESS<br><b>5201 Landon Rd, Rockville, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><b>10/27/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rockville, Md.</b>                            |
| 24. FUNERAL DIRECTOR'S NAME (Type)<br><b>Charles Judge</b>   |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   | DATE<br><b>OCT 30 1967</b>  |   |

CLEARED WITH MEDICAL EXAMINER - Med

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

14031

|   |                           |  |                                     |
|---|---------------------------|--|-------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |                           | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |                                     |
| c. LENGTH OF STAY in lb <b>1 MO. 25 days</b>  |                           | <b>BETHESDA</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>KENSINGTON GARDENS</b>   |                           | d. STREET ADDRESS<br><b>5901 GREENTREE RD</b>  |                                     |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |                                     |
| 3 NAME OF DECEASED<br>(Type or print) <b>JAMES Buckley BLACK</b>  |                           | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>2</b> Year <b>1967</b>  |                                     |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-9-1884</b> |
| 9. AGE (In years last birthday) <b>83</b> yrs.  |                           | IF UNDER 1 YEAR<br>Months Days Hours Min   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>GREENFIELD, IND</b>   |                           | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                     |
| 13. FATHER'S NAME<br><b>DR. JAMES P. BLACK</b>  |                           | 14. MOTHER'S MAIDEN NAME   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                           | 16. SOCIAL SECURITY NO<br><b>354-18-5049</b>   |                                     |
| 17. INFORMANT <b>wife</b><br><b>Jan S. Black</b>  |                           | Address<br><b>Same as Item 2.</b>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b><br>5/71 DUE TO<br>(b) <b>Pulmonary insufficiency</b><br>DUE TO<br>(c) <b>Emphysema</b>              |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>sev. hours</b><br><b>many months</b><br><b>many years</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Pneumonia</b>  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour "a.m." p.m. <b>19</b>  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that (I) (the hospital) attended the deceased from <b>Nov</b> , 1966, to <b>Oct 2</b> , 1967, that (I) (we) last saw the deceased alive on <b>Sept 26</b> 1967, and that death occurred at <b>2:30</b> P.M. from causes and on the date stated above. |                           |  |                                     |
| 22a. SIGNATURE<br><b>George H. Mitchell</b>   |                           | 22b. DATE SIGNED<br><b>Oct 2, 1967</b>   |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE H. MITCHELL</b>   |                           | 22d. ADDRESS<br><b>11125 Rockville Pike<br/>Rockville, Maryland</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                           | 23b. DATE THEREOF<br><b>10-5-67</b>  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Natl Cem</b>   |                           | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |                                     |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |                           | 25a. REC'D BY REGISTRAR<br><b>OCT 9 1967</b>   |                                     |
|   |                           | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (other than page 3) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card from page 3. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14032

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>WASHINGTON</b>                                       |   | b. COUNTY<br><b>D.C.</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WHEATON</b>   |  | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>UNIVERSITY NURSING HOME</b>   |  | d. STREET ADDRESS<br><b>1629 COLUMBIARO WU</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>SAMUEL (NO MIDDLE NAME) BLOCK</b>   |  |   | 4 DATE OF DEATH<br>Month <b>10</b> Day <b>21</b> Year <b>1967</b> |   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/1/1883</b>                               | 9. AGE (In years lost birthday)<br><b>84</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>21</b> Hours <b>00</b> Min <b>00</b>                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BUSINESSMAN</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>POLAND</b>                              |   |
| 13. FATHER'S NAME<br><b>ABRAHAM</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>                        |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO<br><b>308-30-6874</b>  |   | 17. INFORMANT <b>Mrs Ruth Frey</b> Address<br><b>1629 Columbia Rd</b>                             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6-7002</b>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)  | (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/19, 1967</b> to <b>10/21, 1967</b> that (I) (we) last saw the deceased alive on <b>10/21, 1967</b> and that death occurred at <b>10:24 AM</b> , from causes and on the date stated above.                              |  |   |   |   |   |
| 22a. SIGNATURE<br><b>Walter E. Goozh, M.D.</b>   |  | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                           | 22b. DATE SIGNED<br><b>10/21/67</b>                               |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Walter E. Goozh, M.D.</b>   |  | 22d. ADDRESS<br><b>2309 Shorefield Rd., Wheaton, Md.</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>Oct 22-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>United Hebrew Cem.</b>   | 23d. LOCATION (City or town)                                      | (County)  | (State)<br><b>Staten Island, N.Y.</b>   |
| 24. FUNERAL DIRECTOR<br><b>Bernard Nizansky/Son - 3501-14 St W</b>   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 24 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #11 infor. taken from birth cert.

CERTIFICATE OF DEATH

14033

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b>   |   | c. LENGTH OF STAY IN 1b<br><b>Takoma Park</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington San &amp; Hospital</b>   |   | d. STREET ADDRESS<br><b>8510 Flower Ave.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Baby Boy</b>   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>18</b> Year <b>67</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 18, 1967</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><b>15 1</b>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Takoma Park, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/>   |   |
| 13. FATHER'S NAME<br><b>Barry James Bloomer</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Donna Juanita Brady</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><b>Barry Bloomer, Takoma Park, Md.</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple abnormalities</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>31 wks. gestation</b><br>(c) <b>44 min</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br><b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above  |   |   |   |
| 22a. SIGNATURE<br><b>Emma Hughes</b>   |   | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>E. Hughes, M.D.</b>  |   | 22d. ADDRESS<br><b>831 University Blvd., E., Silver Spring</b>  |   |
| 23a. BURIAL, CREMAT., REMOVAL (Specify)<br><b>Cremation</b>  | 23b. DATE THEREOF<br><b>10-19-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington San &amp; Hospital Takoma Park, Montg., Md.</b>   | 23d. LOCATION (City or Town) (County) (State)   |
| 24. FUNERAL DIRECTOR<br><b>J. Ruffcorn, 7600 Carroll Ave., Takoma Park, Md.</b>  |   | 25a. DATE OF REGISTRATION<br><b>OCT 20 1967</b> 25b. SIGNATURE<br><b>John Ruffcorn</b>  |   |





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14034

4020

FOR STATE HEALTH DEPT.

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a STATE <u>MARYLAND</u> b COUNTY <u>Montgomery</u>   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>   |  | c LENGTH OF STAY IN 1b <u>D.O.A.</u>   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to., give street address) <u>Suburban</u>  |  | d STREET ADDRESS <u>6416 Shadow Rd</u>   |  |
| 3 NAME OF DECEASED (Type of print)<br>First <u>FLEMING</u> Middle <u>B</u> Last <u>BOMAR</u>  |  | 4 DATE OF DEATH<br>Month <u>Oct</u> Day <u>24</u> Year <u>1967</u>   |  |
| 5 SEX <u>M</u>  | 6 COLOR OR RACE <u>W</u>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH <u>12-2-14</u> 52 yrs  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>  |  | 10b KIND OF BUSINESS OR INDUSTRY <u>EVANS, PHILLIPS &amp; Co</u>   |  |
| 11 BIRTHPLACE (State or foreign country) <u>SPARTENBURG S. CAROLINA</u>   |  | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13 FATHER'S NAME <u>HORACE BOMAR</u>  |  | 14 MOTHER'S MAIDEN NAME <u>MARLIE BROWN</u>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1941-1943</u>   |  | 16 SOCIAL SECURITY NO. <u>6416 SHADOW RD</u>   |  |
| 17 INFORMANT (wife) <u>Doris Bomar</u>  |  | Address <u>6416 SHADOW RD</u>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis,, descending branch, left coronary</u><br>DUE TO (b) <u>Advanced Coronary arteriosclerosis</u><br>DUE TO (c) <u></u>  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u><br><u>years</u>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |  |  | 9 WA. AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 8) <u></u>  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>   | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u></u>  | 20f (City or town) (County) (State) <u></u>  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>John B. Ball</u> M.D.   |  | 22. DATE SIGNED <u>10/24/67</u>  |  |
| EXAMINER'S NAME (Type) <u></u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <u>Suitland, Maryland</u> |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   | 23b DATE THEREOF <u>10/25/67</u>   | 23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>  | 23d LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>                       |
| 24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u> ADDRESS <u>5130 Wisconsin Avenue, N.W., Wash. D. C. 20016</u>   |  | 25a REC'D BY REGISTRAR <u>OCT 26 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in, the funeral director may be retained to take the body to the funeral home. After this certificate has been signed by the attending physician and completely filled in, the funeral director may be retained to take the body to the funeral home. After this certificate has been signed by the attending physician and completely filled in, the funeral director may be retained to take the body to the funeral home.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b>      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Rockville</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>207 Upton Street</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>MARY</b><br>Middle<br><b>ELIZABETH</b><br>Last<br><b>BRIDGES</b>  |                                  | 4. DATE OF DEATH<br>Month<br><b>October</b><br>Day<br><b>15</b><br>Year<br><b>19 67</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 9, 1916</b> |
| 9. AGE (In years last birthday)<br><b>51</b> yrs   |                                  | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Paris, Illinois</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Karl F. Miller</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ethel Ogden</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>577-24-9881</b>   |  |
| 17. INFORMANT<br><b>Robert W. Bridges-Item # 2</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma Lung c metastases</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>13 MOS.</b> |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>May 1967</b> 19 to <b>10/15/67</b> , 19, that I last saw the deceased alive on <b>10/15/67</b> , 19, and that death occurred at <b>3:20 AM</b> , from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Henry C. Servogs M.D.</b>   |                                  | DATE SIGNED<br><b>10/15/67</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Henry C. Servogs M.D.</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>5413 Cedar Lane Bethesda Md</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10/17/67</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rockville</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Rockville, Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Tyson Wheeler</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>OCT 17 1967</b>   |  |
| ADDRESS<br><b>Rockville, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



4031

## CERTIFICATE OF DEATH

1-1036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by medical examiner Dr. Bledyn B. Rapp  
Baltimore, Md.

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |   | b. COUNTY<br><b>Montgomery</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b>  |                                  | c. LENGTH OF STAY IN IS<br><b>23 Mos. 19 Days</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>University Nursing Home</b>  |                                  |   | d. STREET ADDRESS<br><b>717 Lowander Lane</b>                           |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Yette</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>19</b> Year <b>1967</b> |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Cauc.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1890</b>   |  | 9. AGE (In years last birthday)<br><b>77</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Russia</b>                                     |   |
| 13. FATHER'S NAME<br><b>Louis Katz</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                              |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>579-01-8186</b>  |   | 17. INFORMANT<br><b>Harry Brott, Same as 2</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>arteriosclerotic heart disease with hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>-----</b><br>(c) <b>-----</b> |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 yrs.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes Mellitus</b>  |                                  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                   |   |
| 20f. (City or town)   |                                  | (County)  |   | (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 13, 1967</b> to <b>Oct 19, 1967</b> that (I) (we) last saw the deceased alive on <b>Sept 13, 1967</b> , and that death occurred at <b>2:00 PM</b> from causes on and on the date stated above.   |                                  |   |   |  |   |
| 22a. SIGNATURE<br><b>B. P. Lafsky</b>   |                                  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><b>Oct 19, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>B. P. Lafsky, M. D.</b>  |                                  | 22d. ADDRESS<br><b>2025 I Street N. W. Washington, D. C.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>10-22-1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Geo. Wash. Cemetery</b>   |   |
| 23d. LOCATION (City or Town)<br><b>Hyattsville, Md.</b>   |                                  | (County)  |   | (State)  |   |
| 24. FUNERAL DIRECTOR<br><b>Frederick Funeral Home</b>   |                                  | ADDRESS<br><b>42179 20th Ave</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 24 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Orlando Judge</b>  |                                  |   |   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

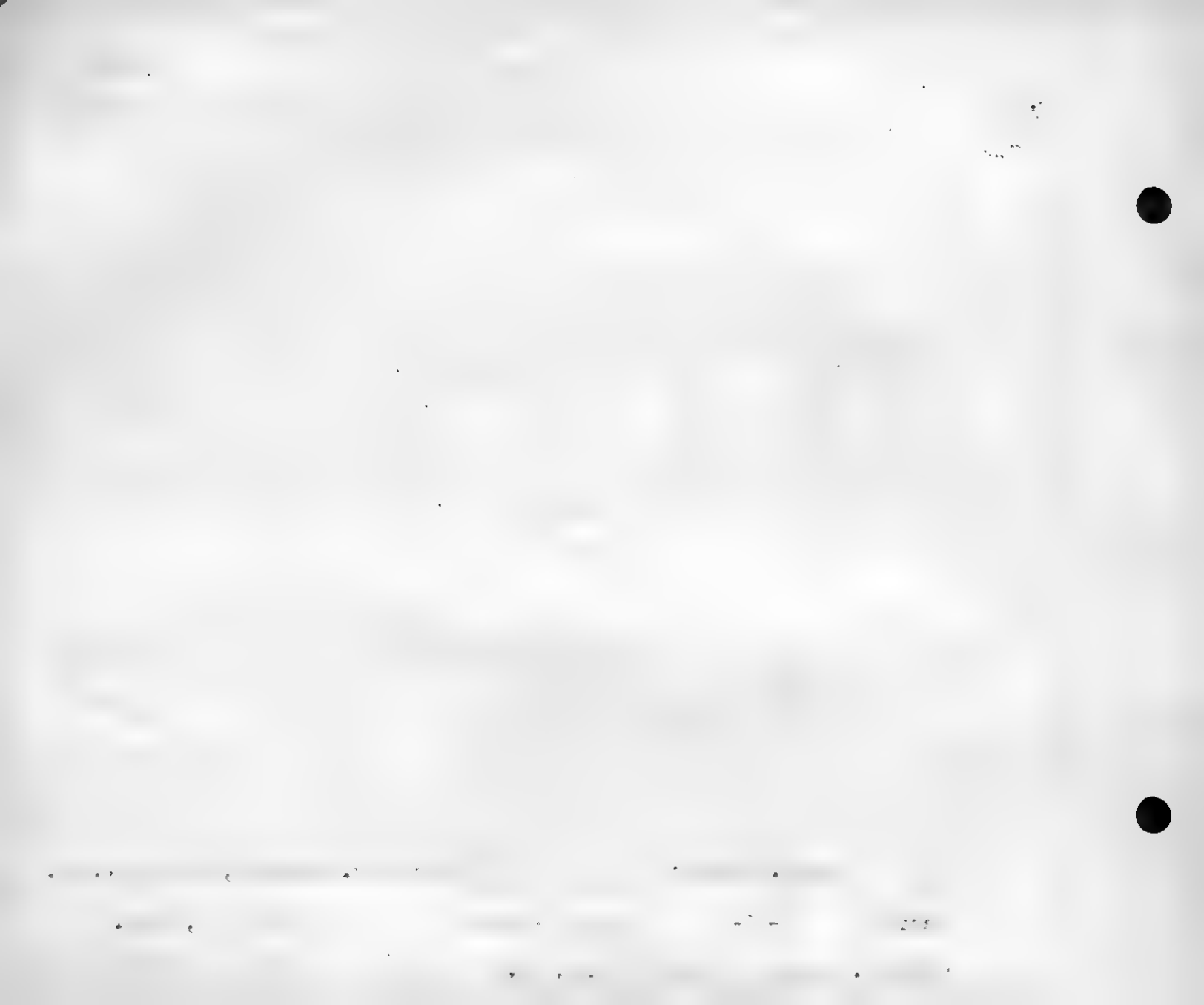
VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14037

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>  |   | c. LENGTH OF STAY IN 1b<br><b>5 days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SAN., + HOSPITAL</b>  |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Burtonsville</b>   |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>BETTY MAE BROWN</b>  |   | 4 DATE OF DEATH<br>Month <b>October</b> Day <b>15</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Fe</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/16/07</b>  |
| 9. AGE (In years lost birthday)<br><b>60</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>hswf</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Tennessee</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Thomas MARSHALL</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>MAGGIE MANESS</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |   |
| 17. INFORMANT<br><b>HOSPITAL RECORDS</b>  |   | Address <b>---</b>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema (+atelectasis)</b><br>DUE TO <b>Congestive heart failure</b><br>(b) <b>arteriosclerotic heart disease</b><br>DUE TO <b>---</b><br>(c) <b>---</b> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CVA / uremia - polycystic + sclerotic kidney disease</b>  |   |   |   |
| 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>73-4 days</b>  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>decease</b>  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>---</b> p.m. <b>19</b>  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>---</b>   | 20f (City or town) (County) (State)<br><b>---</b>                         |
| 21 I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1967, to <b>Oct 15</b> , 1967, that (II) (we) last saw the deceased alive on <b>Oct 15</b> , 1967, and that death occurred at <b>3:00</b> P.M. from causes on and on the date stated above                           |   |   |   |
| 22a SIGNATURE<br><b>John R. Spencer</b>   |   | 22b. DATE SIGNED<br><b>10-15-67</b>   |   |
| 22c (PHYSICIAN'S NAME (Type) <b>John R. Spencer</b>   |   | 22d. ADDRESS<br><b>Takoma Pk Hospital, Takoma Pk. Md.</b>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b DATE THEREOF<br><b>10-23-67</b>   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Goshen Cemetery</b>   | 23d LOCAT ON (City or Town) (County) (State)<br><b>Church Hill, Tenn.</b> |
| 24. FUNERAL DIRECTOR<br><b>Francis H. Barber</b>  |   | 25a REC'D BY REGISTRAR<br>DATE <b>OCT 17 1967</b>   |   |
| ADDRESS<br><b>Laytonsville, Md.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Michael J. Barber</b>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b><br/> <span style="font-size: 1.5em;">14038</span> </div>  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b> <u>Montgomery</u> <b>MARYLAND</b><br><b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br><b>c. LENGTH OF STAY IN 1h</b> <u>2 1/2 Months</u><br><b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>University Nursing Home</u> |  |  |   |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br><b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>Montgomery</u><br><b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br><b>d. STREET ADDRESS</b> <u>4600 Connecticut Ave. N.W. Wash D.C.</u><br><b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |
| <b>3. NAME OF</b><br>(Type or print) <u>Dorothy Anita</u> <b>First</b><br><u>Brown</u> <b>Middle</b><br><u></u> <b>Last</b>  |  |  | <b>4. DATE OF DEATH</b><br><u>10</u> <b>Month</b> <u>4</u> <b>Year</b> <u>1967</u>  |  |  | <b>5. SEX</b><br><u>F</u>   |  |  | <b>6. COLOR OR RACE</b> <u>Cas.</u>  |  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| <b>8. DATE OF BIRTH</b><br><u>11-29-1893</u>   |  |  | <b>9. AGE</b> (In years last birthday) <u>73</u> yrs.<br>IF UNDER 1 YEAR: Months <u></u> Days <u></u><br>IF UNDER 24 HRS.: Hours <u></u> Min. <u></u> |  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>   |  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore Md.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>Charles Schilling</u>   |  |  |   |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Minnie</u>  |  |  |  |  |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br>(If yes give war or dates of service)  |  |  |   |  |  | <b>16. SOCIAL SECURITY NO.</b> <u>578-44-3956</u><br><b>17. INFORMANT</b> <u>James R. Brown</u> <b>Address</b> <u>4011 Blackpool Road Rockville, Maryland</u>   |  |  |  |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <u>Myocardial Failure</u><br>DUE TO (b) <u>Pneumonia - atelectasis</u><br>DUE TO (c) <u>Bronchitis - severe - acute</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |   |  |  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>48 hours</u><br><u>92 hours</u>  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b><br><u>Cornary artery disease; Cong heart failure; Central vasc. insufficiency; generalized severe arteriosclerosis</u>   |  |  |   |  |  |   |  |  |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                      |  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  | <b>20f. (City or town) (County) (State)</b>  |  |  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1960</u> , <b>to</b> <u>Oct 4, 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Oct 4 1967</u> , <b>and that death occurred at</b> <u>8:30 AM</u> , <b>from the causes and on the date stated above.</b>  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Thomas E. Curtin</u>   |  |  |   |  |  | <b>22b. DATE SIGNED</b><br><u>Oct. 4, 1967</u>  |  |  | <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Thomas E. Curtin</u><br><b>22d. ADDRESS</b> <u>4600 Connecticut Ave. N.W. Wash D.C.</u>       |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |  |  | <b>23b. DATE THEREOF</b> <u>Oct. 7, 1967</u>  |  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>  |  |  | <b>23d. LOCATION</b> (City, town or county) (State) <u>Suitland Maryland</u>   |  |  |  |  |  |
| <b>24. FUNERAL DIRECTOR</b> <u>Wm. E. Thomas</u> <b>Address</b> <u>8434 Georgia Avenue Silver Spring, Md.</u><br><u>Wm. E. Thomas</u> <u>Wm. E. Thomas, Inc.</u>   |  |  |   |  |  | <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u><br><b>DATE</b> <u>OCT 9 1967</u>  |  |  | <b>25b. REGISTRAR'S SIGNATURE</b>  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14039

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>   |  | c. LENGTH OF STAY IN 1b<br><u>15.1</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Potomac Valley Nursing Home</u>   |  | d. STREET ADDRESS<br><u>720 Beall Ave.</u>  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <u>Erma</u> Middle <u>L</u> Last <u>Brown</u>   |  | 4 DATE OF DEATH<br>Month <u>10</u> Day <u>2</u> Year <u>1967</u>  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/23/84</u>   |
| 9. AGE (In years lost birthday) <u>82 yrs</u>  |  | IF UNDER 1 YEAR Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>H. Wife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>Laytonsville Md.</u>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13 FATHER'S NAME<br><u>George Gaither</u>  |  | 14 MOTHER'S MAIDEN NAME<br><u>Olivia Layton</u>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |  | 16 SOCIAL SECURITY NO<br><u>57-07-0977A</u>   |  |
| 17 INFORMANT<br><u>Mr. Charlie G. Brown Same as #2</u>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular thrombosis</u><br>DUE TO<br>(b) <u>cerebral arteriosclerosis</u><br>DUE TO<br>(c) <u>last</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o.m.</u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-18, 1967</u> to <u>10-2, 1967</u> that (I) (we) last saw the deceased alive on <u>9-23, 1967</u> , and that death occurred at <u>8:25 M.</u> from causes and on the date stated above   |  |   |  |
| 22a. SIGNATURE<br><u>D. C. Bucy</u>  |  | 22b. DATE SIGNED<br><u>10-2-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>D. C. Bucy</u>  |  | 22d. ADDRESS<br><u>1809 Veirs Mill Rd Rockville Md</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>10-4-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ivy Hill</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Upperville Virginia</u>                      |
| 24. FUNERAL DIRECTOR<br><u>Francis H. Barber</u>   |  | 25a. REC'D BY REGISTRAR<br><u>OCT 5 1967</u>  |  |
| ADDRESS<br><u>Laytonsville, Md.</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. [Signature]</u>   |  |

18

## CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>   |  | c. LENGTH OF STAY IN TB<br><u>SILVER SPRING</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>HOLY CROSS HOSPITAL</u>   |  | d. STREET ADDRESS<br><u>8408 GALVESTON ROAD</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>REBECCA</u> First <u>G. BRYAN</u> Middle Last  |  | 4. DATE OF DEATH<br>Month <u>10</u> - Day <u>21</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12/24/85</u>  |
| 9. AGE (In years last birthday)<br><u>81</u> yrs   |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>Kentucky</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Wren Wrenkenson</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Laura Gates</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><u>220-20-1260-A</u>   |  |
| 17. INFORMANT<br><u>Mrs. Phillip Mixsell</u>   |  | Address<br><u>8400 Cleveland Kt.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>uremia</u><br>DUE TO (b) <u>congestive heart failure</u><br>DUE TO (c) <u>carcinoma, right breast</u>                                  |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u><br><u>40 days</u><br><u>10 MON.</u>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Hemorrhage, Gastric</u>  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1967, to <u>Oct 21</u> , 1967, that (I) <u>was</u> last saw the deceased alive on <u>Oct 21</u> 1967, and that death occurred at <u>1:10 PM</u> , from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><u>George B Patrick Jr</u>   |  | 22b. DATE SIGNED<br><u>10-21-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>George B Patrick Jr MD</u>  |  | 22d. ADDRESS<br><u>9221 Coleridge Rd Silver Spring, Md</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>10/25/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Johnston Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Johnston City, Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Warner E. Dimpfren Inc.</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 26 1967</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers / Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



## CERTIFICATE OF DEATH

|   |   |  |  |
|---|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>   |   | c. LENGTH OF STAY IN TB <u>3 wks.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>9807 Hillridge Dr., Kensington, Md.</u> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>9807 Hillridge Dr., Kensington</u>   |   | d. STREET ADDRESS <u>Kensington, Md.</u>   |  |
| 3 NAME OF DECEASED (Type or print)<br><u>MARIE</u> First <u>Atterbury</u> Middle <u>Burkhard</u> Last   |   | 4 DATE OF DEATH<br>Month <u>Oct.</u> Day <u>13</u> Year <u>1967</u>  |  |
| 5 SEX <u>Female</u>   | 6 COLOR OR RACE <u>white</u>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>              | 8 DATE OF BIRTH<br><u>Oct. 20, 1884</u> 82 yrs   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>   | 9. AGE (In years last birthday)<br><u>82</u> yrs   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>Minnesota</u>  |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13 FATHER'S NAME<br><u>Edward Atterbury</u>   |   | 14 MOTHER'S MAIDEN NAME<br><u>Jennie Woodward</u>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u> <u>none</u>   |   | 16 SOCIAL SECURITY NO <u>none</u>  |  |
| 17 INFORMANT<br><u>Eleanor B. Steadman (above)</u>  |   | Address  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO <u>Coronary artery sclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>1 yr</u><br>(c) <u>1 hour</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u> p.m.   | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/23, 1967</u> to <u>10/13, 1967</u> , that (I) (we) last saw the deceased alive on <u>10/13, 1967</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above  |   |  |  |
| 22a SIGNATURE<br><u>Joseph J. Wallace</u>   |   | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                                    | 22b DATE SIGNED<br><u>10/13/67</u>   |
| 22c PHYSICIAN'S NAME (Type)<br><u>JOSEPH J. WALLACE M.D.</u>  |   | 22d ADDRESS<br><u>5817 LENOX ROAD BETHESDA, MD</u>   |  |
| 23a BURIAL CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   | 23b. DATE THEREOF<br><u>10-13-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Suitland, Maryland</u>                       |
| 24 FUNERAL DIRECTOR<br><u>Robert G. Humphrey</u>  |   | ADDRESS<br><u>Bethesda, Maryland</u>   | 25a REC'D BY REGISTRAR<br><u>Charles Judge</u>   |
| 25b REGISTRAR'S SIGNATURE   |   | DATE <u>OCT 16 1967</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

Coroner (Dr. Ball) contacted and approves JPM





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14042

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>   |  | c. LENGTH OF STAY IN TB <b>1 1/2 hrs.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>   |  | e. STREET ADDRESS <b>New Hampshire Ave.</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>Anna SNOWDEN</b>   |  | 4. DATE OF DEATH <b>Oct. 26 1967</b>   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>7-27-96</b>  |
| 9. AGE (In years last birthday) <b>71</b> yrs   |  | 10. IF UNDER 1 YEAR: Months <b>26</b> Days <b>26</b> Hours <b>19</b> Min <b>67</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>Francis Snowden</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Frances Stabler</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>   |  | 16. SOCIAL SECURITY NO <b>-</b>  |  |
| 17. INFORMANT <b>Montgomery General Hospital</b>  |  | Address <b>Olney, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Unrecorded ischemic</b><br>DUE TO <b>Rupture of aorta</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Abdominal aortic aneurism</b><br>(b)<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b><br><b>2 hrs</b><br><b>10 yrs</b> |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year <b>10/26/67</b><br>Hour a.m. <b>5</b> p.m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>56</b>   | 20f. (City or town) <b>10/26/67</b> (County) (State)                             |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/26/67</b> to <b>10/26/67</b> , that (I) (we) last saw the deceased alive on <b>10/26/67</b> , and that death occurred at <b>5am</b> M, from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <b>Dr. Charles Ligon</b>   |  | 22b. DATE SIGNED <b>10/26/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles Ligon</b>   |  | 22d. ADDRESS <b>Sandy Spring Md</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>  | 23b. DATE THEREOF <b>10-26-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>J. Wm. Lee Sons</b>  | 23d. LOCATION (City or Town) (County) (State) <b>Mass. Ave. Washington, D.C.</b> |
| 24. FUNERAL DIRECTOR <b>Francis H. Barber Funeral Home</b>  |  | 25a. REC'D BY REGISTRAR <b>Laytonville</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  | DATE <b>OCT 30 1967</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G394 10/27/67 ph

4038

CERTIFICATE OF DEATH

14043

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |   | c. LENGTH OF STAY IN 1b<br><u>6 weeks</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban Manor Nursing Home</u>  |   |  | d. STREET ADDRESS<br><u>9121 Pintor Street</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Nellie Lee Page</u>   |   |  | 4 DATE OF DEATH<br>Month Day Year<br><u>October 17 19 67</u>  |  |   |
| 5 SEX<br><u>Female</u>  | 6 COLOR OR RACE<br><u>White</u>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>October 29, 1883</u>  | 9 AGE (In years lost birthday)<br><u>83 yrs</u>  | IF UNDER 1 YEAR<br>Months Days Hours Min<br><u>9/1 83 yrs</u>                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ireland</u>                                    |   |
| 13. FATHER'S NAME<br><u>Michael Lee</u>   |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ellen Miskell</u>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO<br><u>213-56-9974</u>   |   | 17. INFORMANT<br><u>Maru C. Ryan</u> <u>9121 Pintor Street Silver Spring, Md</u>                         |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u><br>DUE TO (b) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 MINUTES</u><br><u>20 YEARS</u>                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 10</u> , 19 <u>67</u> , to <u>OCT. 17</u> , 1967, that (I) <del>was</del> saw the deceased alive on <u>OCT. 17</u> , 1967, and that death occurred at <u>4:35 PM</u> , from causes and on the date stated above   |   |  |   |  |   |
| 22a. SIGNATURE<br><u>Joseph Connor</u>  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                       | 22b. DATE SIGNED<br><u>OCT. 17, 1967</u>  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Joseph Connor</u>  |   | 22d. ADDRESS<br><u>9420 Old Georgetown Rd., Bethesda, Md.</u>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>137</u>   | 23b. DATE THEREOF<br><u>Oct. 20, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D. C.</u>                                |   |
| 24. FUNERAL DIRECTOR<br><u>Thomas E. Schuchman, Inc.</u>  |   | ADDRESS<br><u>8434 Georgia Avenue, Silver Spring, Md.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>OCT 20 1967</u>  |   |
|   |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>William Judge</u>   |   |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14044

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 74 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>DOA</u>   |  | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u><br>d. STREET ADDRESS <u>6603 Hillendale Road</u><br>e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print) <u>ROCHEL STEWART CAMERON</u><br>4 DATE OF DEATH <u>10 11 67</u>  |  | 5 SEX <u>MALE</u> 6 COLOR OR RACE <u>WHITE</u> 7 EVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH <u>Oct 20 1897</u> 9 AGE (In years last birthday) <u>67</u> yrs  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Clerk</u> 10b KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u> 11 BIRTHPLACE (State or foreign country) <u>New York</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 13 FATHER'S NAME <u>Joseph P. CAMERON</u> 14 MOTHER'S MAIDEN NAME <u>Caroline Babcock</u>  |  |
| 15 WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW II Navy</u> 16 SOCIAL SECURITY NO. <u>same as above</u> 17 INFORMANT <u>Frances Cameron</u> Address <u>same as above</u>   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u><br>421 DUE TO (b) <u>Cardio Vascular Disease.</u><br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>years -</u>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>   |  |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>  |  | 22. DATE SIGNED <u>10/11/67</u><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town or county) <u>Mont. Co., Md.</u>   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b DATE THEREOF <u>10/16/67</u>   |  |
| 23c NAME OF CEMETERY OR CREMATORY <u>PITTSFIELD CEM.</u>   |  | 23d LOCATION (City or Town) (County) (State) <u>PITTSFIELD, MASS.</u>  |  |
| 24. FUNERAL DIRECTOR <u>JOS GAWLER'S SONS 5130 WIS. AVE NW WASH, D.C.</u>  |  | 25a REC'D BY REGISTRAR <u>OCT 18 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14045

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b> 15.1   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>  |   | d. STREET ADDRESS<br><b>3809 Elby St.</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>BERTHA E. CAMPBELL</b>  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>2</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 25, 1885</b>                                  |
| 9. AGE (In years lost birthday)<br><b>82 yrs</b>  |   | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>2</b> Hours <b>15</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Sharon, Vermont</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Carlos Thurston</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Emma Hunt</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>Doris Tritle - same above - daughter</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left Lymphocytes and Relative Counts - Human, 5 days</b><br>DUE TO<br>(b) <b>Left lymphocytes</b><br>DUE TO<br>(c) <b>Cancer of the urinary bladder</b>                        |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>6 months</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Sept 1</b> , 19 <b>67</b> , to <b>Oct 2</b> , 19 <b>67</b> , that (I) <del>did</del> saw the deceased alive on <b>Oct 1</b> , 19 <b>67</b> , and that death occurred at <b>1:30 AM</b> , from causes and on the date stated above. |   |   |  |
| 22a. SIGNATURE<br><b>Michael A. Dobridge</b>  |   | 22b. DATE SIGNED<br><b>Oct 3, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Michael R. Dobridge</b>  |   | 22d. ADDRESS<br><b>1260 Parkland Drive, Rockville, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10/5/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Leyden Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Springfield, Mass.</b> |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home</b>   |   | 25a. REC'D BY REGISTRAR<br><b>1531 Rock. Pike</b><br><b>Rockville, Md.</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   | DATE <b>OCT 4 1967</b>  |  |





MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14042

14047

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the paper papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                              |   |  |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>8700 Darnestown Road</u>  |                              | d. STREET ADDRESS<br><u>8700 Darnestown Road</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Mary</u> First <u>Harley</u> Middle <u>Carter</u> Last   |                              | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>19</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 24 1886</u> |
| 9. AGE (In years last birthday)<br><u>81</u> yrs   |                              | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Montgomery Cty. Md.</u>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Harry C. Harley</u>  |                              | 14. MOTHER'S MAIDEN NAME<br><u>Anna McCormick</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>218-33-2875</u>   |  |
| 17. INFORMANT<br><u>Guy L. Carter</u>  |                              | Address <u>Husband's</u><br><u>8700 Darnestown Rd.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>7 5 50 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Arterial Sclerosis</u><br>DUE TO (c) <u>Senility</u> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mo</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>October 19 65</u> to <u>October 19 67</u> that (I) (we) last saw the deceased alive on <u>Oct 19 1967</u> , and that death occurred on <u>Oct 19 1967</u> , from causes on and on the date stated above.  |                              |   |  |
| 22a. SIGNATURE<br><u>Corinne Cooper</u> M.D.   |                              | 22b. DATE SIGNED<br><u>10-19-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>CORINNE COOPER</u>  |                              | 22d. ADDRESS<br><u>104 S. Washington St. Rockville</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>10-23-67</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rockville Cemetery</u>  |                              | 23d. LOCATION (City or Town) (County) (State)<br><u>Rockville, Maryland</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |                              | 25a. REC'D BY REGISTRAR<br><u>OCT 25 1967</u>   |  |
|  |                              | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4043

CERTIFICATE OF DEATH

14048

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>District of Columbia</u> b. COUNTY                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>65 days</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>   |                                  | d. STREET ADDRESS<br><u>1333 Childress Street, N.E.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Raymond</u> Middle <u>Calvin</u> Last <u>Carter, Jr.</u>   |                                  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>21</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>5 October 1947</u>         |
| 9. AGE (In years last birthday)<br><u>20 yrs</u>   |                                  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Student</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Washington, D.C.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>Raymond C. Carter, Sr.</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Viola Traynham</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>579-64-0810</u>  |   |
| 17. INFORMANT<br><u>The Medical Record</u>   |                                  | Address<br><u>The Clinical Center, Bethesda, Maryland</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>  </u><br>DUE TO<br>(c) <u>  </u>                             |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Pericardial effusion, bilateral pleural effusion</u>   |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug. 17</u> , 1967, to <u>Oct. 21</u> , 1967, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Oct. 21</u> , 1967, and that death occurred at <u>8:20 M.</u> from causes and on the date stated above. |                                  |  |   |
| 22a. SIGNATURE<br><u>Michael Emmer</u>   |                                  | 22b. DATE SIGNED<br><u>22 October 1967</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Michael Emmer, M.D.</u>   |                                  | 22d. ADDRESS<br><u>Institutes of Health, Bethesda, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>10-27-67</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Harmony Memorial</u>  |                                  | 23d. LOCATION (City or town) (County) (State)<br><u>Landon, Md.</u>  |   |
| 24. FUNERAL DIRECTOR<br><u>Fraziers</u>  |                                  | ADDRESS<br><u>38 R. I. Ave., N.W., Wash, D.C. 20001</u>  |   |
| 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 25 1967</u>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14019

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> F.O.A.  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  | d. STREET ADDRESS <u>400-N. Washington St.</u>   |   |
| 3. NAME OF DECEASED (Type of print) <u>Thelma Eleanor Carter</u>   |  | 4. DATE OF DEATH <u>Oct. 24</u> 19 <u>67</u>   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>colored</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/25/16</u> 50 yrs   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) <u>S.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>UNKNOWN</u>   |  | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT  |  | Address  |   |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocarditis</u><br>DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u><br>DUE TO (c)  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  | 9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <u>John G. Ball</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/25/67</u>  |   |
|  |  | Address (Street, city, town, or county)  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF <u>11/3/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>COUNTY CEM.</u>  | 23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE MD</u>                             |
| 24. FUNERAL DIRECTOR: <u>Robert L. Snowden</u>   |  | 25a. RECD BY REGISTRAR: <u>NOV 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |
| ADDRESS <u>ROCKVILLE, MD</u>   |  | DATE   |   |





## CERTIFICATE OF DEATH

14050

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  | c. LENGTH OF STAY in lb<br><b>13 days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>  |  | d. STREET ADDRESS<br><b>257 Congressional Lane</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>ELIZABETH M. CHAMBERLIN</b>   |  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>2</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 27, 1910</b>  |
| 9. AGE (In years last birthday) <b>57</b> yrs   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>New York</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |   |
| 13. FATHER'S NAME<br><b>Walter L. Messer</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Amelia McFride</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>077-07-2353</b>  |   |
| 17. INFORMANT<br><b>Husband Eugene W. Chamberlin</b>  |  | Address <b>Same as Item 2.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I: DEATH WAS CAUSED BY:<br><b>576X</b> IMMEDIATE CAUSE (a) <b>Cerebral Behemini</b><br>DUE TO <b>Stroke (Hypertension) -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO <b>Perforation of intestinal colon</b><br>(c) <b>Perforation of intestinal colon</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b><br><b>12 hrs.</b><br><b>48 hrs.</b>            |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Regional enteritis -</b>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2/2, 1963</b> to <b>10/2, 1967</b> that (I) (we) last saw the deceased alive on <b>10/4, 1967</b> and that death occurred at <b>12:00 P.M.</b> from causes and on the date stated above  |  |   |   |
| 22a. SIGNATURE<br><b>Stephen N. Jones</b>   |  | 22b. DATE SIGNED<br><b>10/4/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>STEPHEN N. JONES</b>   |  | 22d. ADDRESS<br><b>809 Viers Mill Rd., Rockville, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10-6-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rockville, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>1967</b><br>DATE <b>OCT 9 1967</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Virginia</b><br>b. COUNTY <b>Fredericksburg</b>     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>   |  | c. LENGTH OF STAY IN 1b<br><b>56 days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>   |  | d. STREET ADDRESS<br><b>904 Sylvania Ave.</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Robert Welch COBLE, Jr.</b>  |  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>1</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Cauc.</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 8, 1946</b>  |
| 9. AGE (in years lost birthday) yrs<br><b>21</b>  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>1967</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U. S. Marine Corps</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Alexandria, Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Robert W. Coble</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Doris J. Cato</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>Yes 9-9-66--10-1-67</b>  |  | 16. SOCIAL SECURITY NO   |   |
| 17. INFORMANT <b>Fredericksburg</b> Address <b>Virginia</b><br><b>Mr. Robert W. Coble, 904 Sylvania Ave.</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>193.4 Glioblastoma Multiforme</b><br>IMMEDIATE CAUSE (a) <b>193.4</b> DUE TO (b) <b>193.4</b> DUE TO (c) <b>193.4</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (1) (this hospital) attended the deceased from <b>Aug 6, 1967</b> , to <b>Oct. 1, 1967</b> that (1) (we) last saw the deceased alive on <b>October 1, 1967</b> and that death occurred at <b>530 PM</b> , from causes and on the date stated above.  |  |  |   |
| 22a. SIGNATURE<br>   |  | 22b. DATE SIGNED<br><b>Oct. 3, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>B. L. Rish, M. D.</b>  |  | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10/5/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Gardens</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Fredericksburg, Virginia</b>                                    |
| 24. FUNERAL DIRECTOR<br><b>Falls Church Funeral Home</b><br><b>1102 West Broad Street, Falls Church, Virginia</b>   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 6 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br> |



## CERTIFICATE OF DEATH

14052

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |   |
| c. LENGTH OF STAY IN lb<br><b>years</b>  |   | d. STREET ADDRESS<br><b>312 Baltimore Road</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>312 Baltimore Road</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LAWRENCE LEE COLLIER</b>  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>28,</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 24, 1912</b>  |
| 9. AGE (In years last birthday)<br><b>55</b> yrs   |   | 10. IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>months</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>P.E. Co. - Supervisor</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>West Virginia</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U. S.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |   |
| 13. FATHER'S NAME<br><b>Walter Lee Collier</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Lula Ballenger</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes</b>   |   | 16. SOCIAL SECURITY NO.<br><b>577-05003</b>   |   |
| 17. INFORMANT<br><b>wife</b>   |   | Address<br><b>Capitola E. Collier Same as Item 2.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of lung, with generalized</b><br>DUE TO <b>bone metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>(Collet study, no surgery except biopsy)</b><br>(c) <b>(Collet study, no surgery except biopsy)</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 months</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>none</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>none</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. City or town (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 1967, to <b>Oct 28</b> , 1967, that (I) ( <del>we</del> ) last saw the deceased alive on <b>October 28, 1967</b> , and that death occurred at <b>6 A</b> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>W.C. Smith</b>  |   | 22b. DATE SIGNED<br><b>10/28/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm A Linthicum, M.D.</b>  |   | 22d. ADDRESS<br><b>110 S. Washington St - Rockville, Md.</b>  |   |
| 23a. BURIAL, CREMATON, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10-30-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Darnestown Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Darnestown, Maryland</b>                      |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DATE NOV 1 1967</b>   |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



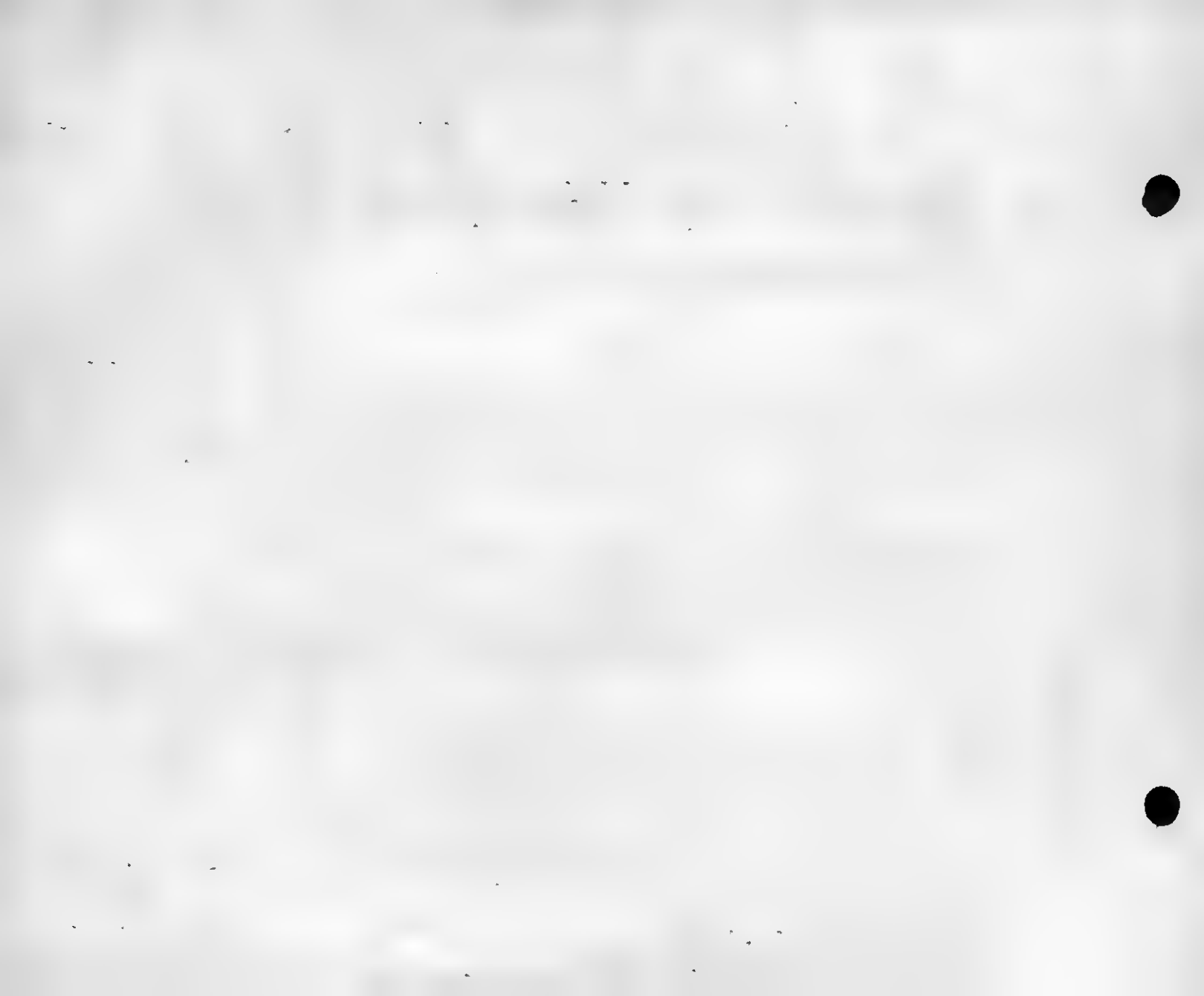
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14053

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |  | c. CITY OR TOWN (If inside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)<br><u>710 Eastmont St.</u>   |  | e. STREET ADDRESS <u>710 Eastmont St.</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Margaret Colliere</u>   |  | 4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1967</u>  |  |
| 5. SEX <u>Fe</u>   | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>26 MAR 4 1897</u>  |
| 9. AGE (In years lost birthday) <u>70</u> yrs  |  | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Newbrighton, Pennsylvania</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Unknown</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO<br><u>yes</u>   |  |
| 17. INFORMANT<br><u>Bette Lindsay Kensington, Md.</u>  |  | 18. ADDRESS <u>3501 Stark Street</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive, Acute intracerebral</u><br>DUE TO (b) <u>hemorrhage, left cerebral hemisphere</u><br>DUE TO (c) <u>lost.</u>   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>Beloen R. Reap</u>   |  | 22. DATE SIGNED <u>10/23/1967</u>  |  |
| EXAMINER'S NAME (Type) <u>BELOEN R. REAP, M.D.</u>   |  | DEPUTY MEDICAL EXAMINER <u>Beloen R. Reap, M.D.</u>  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   | 23b. DATE THEREOF<br><u>Oct 26 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Crematory</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Prince Georges Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Clark E. Wisor</u>   |  | 25a. REC'D BY REGISTRAR <u>OCT 30 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Warner E. Purnhaley, Inc. Silver Spring, Md.</u>  |  | 25c. REGISTRAR'S SIGNATURE<br><u>Beloen R. Reap, Judge</u>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

ANNAPOLIS STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14054

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chevy Chase</u>  |   |
| c. LENGTH OF STAY IN 1b<br><u>1 year</u>   |  | d. STREET ADDRESS<br><u>3414 Turner Lane</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Althea Woodland Nursing Home, 1000 Doleview Dr.</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Clara</u> Middle <u>Wilson</u> Last <u>Comyn</u>   |  | 4. DATE OF DEATH<br>Month <u>10</u> - Day <u>18</u> - Year <u>1967</u>  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/16/1879</u>  |
| 9. AGE (In years lost birthday) yrs<br><u>88</u>   |  | 10. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN Home</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Newcastle, England</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |   |
| 13. FATHER'S NAME<br><u>Charles Wilson</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Margaret Dodd</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO<br><u>047-26-6142</u>  |   |
| 17. INFORMANT<br><u>Mr Raymond H. Comyn</u>  |  | Address <u>3414 Turner Lane Chevy Chase, Md.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u><br>DUE TO <u>Cardiovascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (H) (this hospital) attended the deceased from <u>Oct 16, 1967</u> to <u>Oct 18, 1967</u> , that (H) (we) last saw the deceased alive on <u>10-18-67</u> , and that death occurred at <u>10:30 P.M.</u> from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><u>Bernard A. Fitzgerald</u>   |  | 22b. DATE SIGNED<br><u>10-18-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>BERNARD A. FITZGERALD</u>   |  | 22d. ADDRESS<br><u>217 UNIV BLVD E, S.L.S.P., MD.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Oct. 21, 1967</u>  | 23b. DATE THEREOF  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>George Washington Cem.</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Delphi, Md.</u>                               |
| 24. FUNERAL DIRECTOR<br><u>Walter E. Humphrey, Inc.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14055

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>   |   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><u>Bethesda.</u>  |                               | c. LENGTH OF STAY IN TB   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>5106 Brookview Dr.</u>  |                               | d. STREET ADDRESS<br><u>8012 Old Georgetown Rd</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>George Thomas Coogan</u>   |                               | 4. DATE OF DEATH<br>Month <u>Oct</u> - Day <u>5</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>M.</u>  | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>2/25/1939</u>  |
| 9. AGE (In years lost birthday)<br><u>28</u> yrs   |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>LAWYER</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>CHICAGO, ILLINOIS</u>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>John T. Coogan</u>   |                               | 14. MOTHER'S MAIDEN NAME<br><u>MARIE PEDERSEN</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                               | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><u>John T. Coogan</u>   |                               | 18. ADDRESS<br><u>401 Scot Drive Park Ridge, Ill.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Strangulation by Hanging</u><br>DUE TO (b) <u>117X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>117X</u> |                               |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hours</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>Hung self with garden hose</u>   |   |
| 20c. TIME OF INJURY Month Day Year<br><u>12:30 pm Oct 5 1967</u>   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)<br><u>Yard</u>             |
| 20f. (City or town) (County) (State)<br><u>Bethesda Montgomery Md.</u>   |                               | 21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from<br>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |
| ACTUAL SIGNATURE<br><u>John G. Ball</u>  |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type)<br><u>JOHN G. BALL</u>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 22. DATE SIGNED<br><u>10/5/67</u>  |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| Address (Street, city, town, or county)<br><u>Bethesda, Md.</u>  |                               | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |   |
| 23b. DATE THEREOF<br><u>10-2-67</u>  |                               | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Elmhurst Cemetery</u>  |   |
| 23d. LOCATION (City or Town) (County) (State)<br><u>Elmhurst, Illinois</u>   |                               | 23e. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |   |
| 23f. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                               | 23g. DATE<br><u>OCT 16 1967</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |                               |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner/

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONT.</b>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING, MD.</b>  |   | c. LENGTH OF STAY IN 1b<br><b>TAKOMA PARK</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>HOLY CROSS HOSPITAL</b>   |   | d. STREET ADDRESS<br><b>22 PHILADELPIA AVE</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>HELEN GRANDFIELD COOK</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>10 21 1967</b>   |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-27-93</b>   |
| 9. AGE (In years lost birthday)<br><b>74</b> yrs   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>WASH. D.C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>CHARLES PAXTON GRANDFIELD</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>JENNY MCKEE</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>GEORGE A. COOK JR.</b>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coronary artery thrombosis</b><br>DUE TO <b>myocardial infarction and congestive failure</b><br>(b) <b>Generalized arteriosclerotic cardiovascular disease</b><br>DUE TO <b>Diabetes mellitus</b><br>(c) <b>Diabetes mellitus</b> |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes mellitus</b>  |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (U) (this hospital) attended the deceased from <b>July</b> , 1967, to <b>Oct 21</b> , 1967, that (U) (two) last saw the deceased alive on <b>21 Oct</b> , 1967, and that death occurred at <b>8:30 PM</b> from causes on and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>Ernest E. Harrington MD</b>   |   | 22b. DATE SIGNED<br><b>21 Oct 67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ernest E. Harrington MD</b>   |   | 22d. ADDRESS<br><b>9501 Colasville Rd S. Springfield, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Int. 24-1967</b>   | 23b. DATE THEREOF<br><b>Oct. 24-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Geo. Wash. Cemetery</b>  | 23d. LOCATION (City & Town) (County) (State)<br><b>Spring Rd. Prince Georges Co. Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Takoma Funeral Home</b>   |   | 25. REC'D BY REGISTRAR<br><b>Charles J. Jones</b>   |  |
| 25a. ADDRESS<br><b>254 Carroll Ave NW</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Jones</b>   |  |
| DATE<br><b>OCT 24 1967</b>   |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

4052

14057

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   | c. LENGTH OF STAY IN 1b <u>25 days</u>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Md. &amp; Chevy Chase Md.</u>                                |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  | d. STREET ADDRESS <u>1100 3rd Street NW</u>  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Georgette B. Carlin</u>   |  | 4. DATE OF DEATH <u>Oct. 19</u> 19 <u>67</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/2/01</u>   |
| 9. AGE (In years last birthday) <u>66</u> yrs.   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Housewife</u>  |  | 12. KIND OF BUSINESS OR INDUSTRY   |  |
| 13. FATHER'S NAME <u>George Bigot</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Eugenie Edeni</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>  |  | 16. SOCIAL SECURITY NO <u>215-38-3743A</u>   |  |
| 17. INFORMANT <u>George F. Carlin</u>  |  | Address <u>Potomac Md</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer</u><br>DUE TO <u>metastatic</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>adenocarcinoma of the colon</u><br>(c) |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 21c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  | 21d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 21f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19 _____ to <u>Oct 19</u> , 19 <u>67</u> , that (I) <del>was</del> <u>saw</u> the deceased alive on <u>Oct 18</u> , 19 <u>67</u> , and that death occurred at <u>10:21 M</u> , from causes and on the date stated above                             |  |  |  |
| 22a. SIGNATURE <u>Allen J. O'Neill</u>   |  | 22b. DATE SIGNED <u>10-20-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill MD</u>  |  | 22d. ADDRESS <u>8601 old Georgetown Rd Bethesda Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>10-23-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>  | 23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u>                   |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |  | 25a. REC'D BY REGISTRAR <u>DATE OCT 25 1967</u>  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

4053

14058

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cherry Chase</u>  |  |
| c. LENGTH OF STAY IN 1b<br><u>5 years 11 months</u>  |   | d. STREET ADDRESS<br><u>6424 Brookside Dr.</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Althea Woodland Nursing Home, 1000 Doleview Dr.</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Bertha Maye Cornick</u>  |   | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>27</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>7-3-1886</u>  |
| 9. AGE (In years lost birthday) <u>81</u> yrs  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>homemaker</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Iowa</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>Alexander Ashba</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Ida Owens</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |   | 16. SOCIAL SECURITY NO.<br><u>yes</u>  |  |
| 17. INFORMANT<br><u>Mrs. R.W. Markley, 6424 Brookside Dr. Cherry Chase, Maryland</u>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO (b) <u>Arteriosclerosis - heart disease</u><br>DUE TO (c) <u>Arteriosclerosis generalized</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Cerebral Arteriosclerosis - &amp; Senility</u>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>None</u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>None</u>  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1967</u> to <u>10-27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 27, 1967</u> , and that death occurred at <u>1:25 P.M.</u> from causes and on the date stated above. |   |  |  |
| 22a. SIGNATURE<br><u>Frederic J. Chapman</u> M.D.  |   | 22b. DATE SIGNED<br><u>10-27-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Frederic J. Chapman</u><br><u>1234 - 19th St. N.W.</u>  |   | 22d. ADDRESS<br><u>1234 - 19th St. N.W.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>Nov. 1, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Forest Lawn Memorial Park</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Glendale, California</u> |
| 24. FUNERAL DIRECTOR<br><u>Warner E. Pumphrey, Inc.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>NOV 2 1967</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                           |



## CERTIFICATE OF DEATH

14059

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>   |  |
| c. LENGTH OF STAY IN 1b <u>6 days</u>  |  | d. STREET ADDRESS <u>521 Montgomery House</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Otha</u> First <u>CEISMOND</u> Middle <u>CEISMOND</u> Last  |  | 4. DATE OF DEATH <u>10-15</u> 19 <u>67</u> Month Day Year  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>              | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-29-91</u> 76 yrs                             |
| 9. AGE (In years, last month, day) <u>76</u> yrs   |  | 10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>15</u> Hours <u>19</u> Min <u>67</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Mechanist Fed. Plant</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Electric</u>  |  |
| 11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>unknown</u>   |  | 14. MOTHER'S MARRIAGE NAME <u>unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO <u>678-05-3118</u>  |  |
| 17. INFORMANT <u>Wife - Mable - Same</u> Address <u>Same</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Infarction, multiple, cerebral</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | INTERVAL BETWEEN ONSET AND DEATH <u>3.5 hours</u>  |  |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>                          |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>10-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-14</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M., from causes and on the date stated above.                                   |  |  |  |
| 22a. SIGNATURE <u>D. C. Bucky</u>  |  | 22b. DATE SIGNED <u>10-15-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>D. C. Bucky</u>  |  | 22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Oct. 18, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Damascus, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>  |  | 25a. REC'D BY REGISTRAR <u>OCT 18 1967</u> DATE  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with a form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14060

|   |                                      |   |   |
|---|--------------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY COUNTY</b> MARYLAND   |                                      | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>                                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |                                      | c. LENGTH OF STAY IN 1b<br><b>WHEATON</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>HOLY CROSS HOSPITAL</b>  |                                      | d. STREET ADDRESS<br><b>11311 Viers Mill Rd.</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>LEWIS E CRIST</b>   |                                      | 4 DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>21</b> Year <b>19 67</b>   |   |
| 5 SEX<br><b>M</b>   | 6 COLOR OR RACE<br><b>W</b>          | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                        | 8 DATE OF BIRTH<br><b>3/16/11</b>   |
| 9 AGE (In years, last birthday)<br><b>56</b> yrs  |                                      | 10 IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Superv. Elect. Shop/ N.O.L.</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MARYLAND</b>  |   |
| 11 BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                                      | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Howard Preston Crist</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Myrtie Breedlove Phillips</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>216-18-6240</b>   |   |
| 17. INFORMANT <b>Wife</b><br><b>Ella L. Crist</b>   |                                      | Address<br><b>Same as Item 2.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br><b>16.6</b><br>IMMEDIATE CAUSE (a) <b>Generalized Conflagration</b><br>DUE TO<br>(b) <b>burns of 75% of Body</b><br>DUE TO<br>(c) <b>Surface.</b>  |                                      | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>deceased burned in arc type short circuit fire at work</b>                       |   |
| 20c. TIME OF INJURY Month, Day, Year<br><b>12:30 a.m. 10-15-67</b>  |                                      | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/><br>at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><b>N.O.L. Bldg</b>  |                                      | 20f. (City or town) (County) (State)<br><b>Silver Spring Montgomery Md</b>  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                      |   |   |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b> M.D.  |                                      | 22. DATE SIGNED<br><b>10/21/1967</b>  |   |
| EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP M.D.</b>  |                                      | Address (Street or P.O. number and county)  |   |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>10-25-67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rockville, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |                                      | 25a. REC'D BY REGISTRAR<br><b>OCT 26 1967</b>   |   |
|   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert in original papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |  |  |                                      |  |   |   |
|--|--|---|---|--|--|--------------------------------------|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |  |  |                                      |  |   |   |
| 14056  |  |   |   |  |  |                                      |  |   |   |
| CERTIFICATE OF DEATH   |  |   |   |  |  |                                      |  |   |   |
| 14061  |  |   |   |  |  |                                      |  |   |   |
| 1 PLACE OF DEATH<br>a. COUNTY<br>Montgomery MARYLAND   |  |   |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br>Virginia b. COUNTY<br>Loudoun |                                      |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda   |  |   | c. LENGTH OF STAY IN 1b<br>50 days                    |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Chantilly                                    |                                      |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>The Clinical Center, Bethesda, Maryland  |  |   |   |  | d. STREET ADDRESS<br>Route 1, Box 167  |                                      |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Vivian Gladys Cross  |  |   | 4. DATE OF DEATH<br>Month Day Year<br>October 2 19 67 |  |  |                                      |  |   |   |
| 5 SEX<br>Female  |  | 6 COLOR OR RACE<br>White  |   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br>5 October 1913    |  | 9 AGE (In years last birthday) yrs.<br>53   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Deputy Sheriff  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Government   |   | 11 BIRTHPLACE (County & State or foreign country)<br>Virginia  |  |                                      | 12 CITIZEN OF WHAT COUNTRY?<br>USA                                   |   |   |
| 13. FATHER'S NAME<br>Cassius Downs   |  |   |   |  | 14. MOTHER'S MAIDEN NAME<br>Nellie Rice  |                                      |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |   | 16 SOCIAL SECURITY NO                                 |  | 17. INFORMANT The Medical Records<br>The Clinical Center, Bethesda, Maryland   |                                      |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Disseminated pelvic carcinoma</u><br>199.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) DUE TO |  |   |   |  |  |                                      |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>3 years   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |   |  |  |                                      |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |                                      |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>19   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State) |  |   |   |
| 21. I certify that (A) (this hospital) attended the deceased from August 13, 19 67, to October 2, 19 67 that (A) (we) last saw the deceased alive on October 2, 19 67, and that death occurred at 4:25 P.M., from causes and on the date stated above.   |  |   |   |  |  |                                      |  |   |   |
| 22a. SIGNATURE<br>Kenneth P. Ramming   |  |   |   |  | 22b. DATE SIGNED<br>Oct. 2, 1967   |                                      |  | 22c. PHYSICIAN'S NAME (Type)<br>Kenneth P. Ramming, M.D.  |   |
| 22d. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda, Md.  |  |   |   |  |  |                                      |  |   |   |
| 23a. BURIAL, CREMATION, or other disposal (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>10/5/67  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Chestnut Grove   |  |                                      | 23d. LOCATION (City or Town) (County) (State)<br>Herndon Fairfax Va. |   |   |
| 24. FUNERAL DIRECTOR<br>Muse & Reed, Inc. Leesburg, Va.  |  |   |   |  | 25a. REC'D BY REGISTRAR<br>OCT 5 1967  |                                      | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |   |   |

MEDICAL CERTIFICATION





## CERTIFICATE OF DEATH

14062

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>  |  |
| c. LENGTH OF STAY IN 1b <u>15 days</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dubuehan</u>  |  | d. STREET ADDRESS <u>1 Primrose St.</u>  |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Thomas L. Cullinan</u>   |  | 4. DATE OF DEATH<br>Month <u>10</u> - Day <u>14</u> Year <u>1967</u>   |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. AGE (In years last birthday) <u>77</u> yrs  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Supv. Dept. of Agriculture</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia U.S.A.</u>  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <u>James CULLINAN</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Annie Weber</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |  | 16. SOCIAL SECURITY NO   |  |
| 17. INFORMANT <u>Mrs. Enright - Sister - Same</u>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>DUE TO (b) <u>Thrombosis</u><br>DUE TO (c) <u>Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>2 days</u>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1960</u> to <u>Oct 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-25 PM 19</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <u>J. E. EVERETT</u>   |  | 22b. DATE SIGNED <u>10/14/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>J. E. EVERETT</u>   |  | 22d. ADDRESS <u>7400 Conn. Ave. Kensington, Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 23b. DATE THEREOF <u>10/17/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>  | 23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>                          |
| 24. FUNERAL DIRECTOR <u>DR. CAWLER'S SONS, WASHINGTON, D.C.</u>   |  | 25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

4058

14063

|  |                              |  |   |
|--|------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                              | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>             |   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |   |
| c. LENGTH OF STAY IN 1b <u>1 day</u>   |                              | d. STREET ADDRESS <u>5006 Baltic Ave</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>  |                              | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>Therese Marie Danaher</u>  |                              | 4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>  |   |
| 5 SEX <u>Female</u>  | 6 COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 3, 1907</u> |
| 9. AGE (n years lost birthday) <u>yes</u>  |                              | IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS Hours <u>1</u> Min. <u>1</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Maryland</u>   |                              | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Gerard Joseph Danaher</u>   |                              | 14. MOTHER'S MAIDEN NAME <u>Caroline Horman</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>  |                              | 16. SOCIAL SECURITY NO. <u>none</u>  |   |
| 17. INFORMANT <u>Mrs. Caroline Danaher</u> Address <u>5006 Baltic Avenue Rockville, Maryland</u>   |                              | 18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))   |   |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7543 Congenital heart disease, manifest by</u>   |                              | INTERVAL BETWEEN ONSET AND DEATH   |   |
| DUE TO (b) <u>1. Mitral atresia</u>  |                              |  |   |
| DUE TO (c) <u>2. Premature closure of foramen ovale</u>  |                              |  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-5</u> , 19 <u>67</u> , to <u>10-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-4</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> M, from causes and on the date stated above. |                              |  |   |
| 22a. SIGNATURE <u>George R. Spence</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                              | 22b. DATE SIGNED <u>10/4/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>George R. Spence</u>   |                              | 22d. ADDRESS <u>1515 Highland Drive Silver Spring, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                              | 23b. DATE THEREOF <u>Oct. 6, 1967</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>  |                              | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>   |   |
| 24. FUNERAL DIRECTOR <u>J. B. Thomas</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>   |                              | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |   |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                              | DATE <u>OCT 9 1967</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14064

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |   | c. LENGTH OF STAY IN 1b<br><u>1/2 hr.</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>4607 Overbrook Rd.</u>   |   | d. STREET ADDRESS<br><u>708 Anneslie Rd.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br><u>Winnett</u> First Middle Last<br><u>Shepherd Dashiell</u>   |   | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>28</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>M.</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 2 1902</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Post office</u>   | 9. AGE (in years last birthday)<br><u>65</u> yrs  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Benjamin Dashiell</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Edna Shepherd</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO.<br><u>220-44-6442</u>   |   |
| 17. INFORMANT<br><u>(Wife) Freda Mildred Dashiell</u>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Crown Insubordination acute</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Cardiovascular Disease</u><br>DUE TO<br>(c)  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>Years.</u>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE<br><u>John G Ball</u>  |   | 22. DATE SIGNED<br><u>10/28/67</u>  |   |
| EXAMINER'S NAME (Type)<br><u>John G Ball</u>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><u>7936 Cecile Rd Bethesda, Md.</u>               |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>11/1/1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge</u>  | 23d. LOCATION (City or town) (County) (State)<br><u>Pikesville, Balto. Co. Md.</u>                |
| 24. FUNERAL DIRECTOR<br><u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>   |   | 25a. REC'D BY REGISTRAR<br><u>OCT 30 1967</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14065

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. LENGTH OF STAY IN 1b <u>6 hrs</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmville</u>                   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |  | e. STREET ADDRESS <u>1015 Noridstone St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 3. NAME OF DECEASED (Type or print) <u>Bobby Earl Davis</u> First Middle Last   |  | 4. DATE OF DEATH <u>10</u> Month <u>2</u> Day <u>1967</u> Year   |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>Negro</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-2-67</u> 9. AGE (In years last birthday) <u>23</u> yrs                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State or foreign country) <u>Montgomery Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Theodore Davis</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Mary Lee O'Leary</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO <u>-</u>  |  |
| 17. INFORMANT <u>Theodore Davis</u> Address <u>Home as above</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C.N.S. Damage</u><br>DUE TO (b) <u>Prematurity</u><br>DUE TO (c) <u>-</u>                             |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:30</u> M., from causes and on the date stated above |  |  |  |
| 22a. SIGNATURE <u>Frank Mate Jr.</u> M.D.   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          | 22b. DATE SIGNED   |
| 22c. PHYSICIAN'S NAME (Type)  |  | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF <u>10/5/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Bethesda Montg. MD</u>                        |
| 24. FUNERAL DIRECTOR <u>Mrs. Anelia C. Carter, Administrator</u> ADDRESS  |  | 25a. REC'D BY REGISTRAR  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |

VR A15 15  
25M 1/62

DATE OCT 10 1967





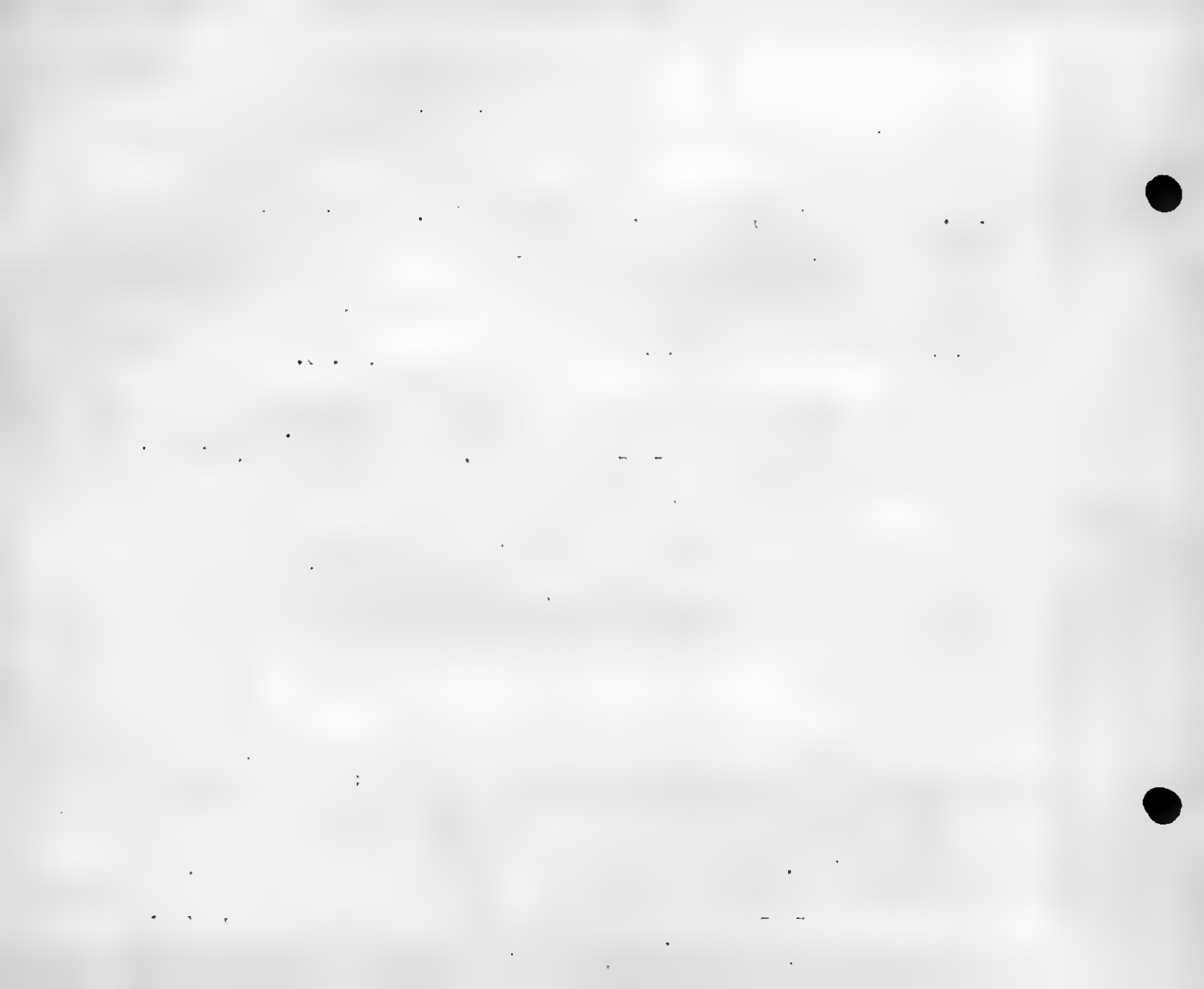
## CERTIFICATE OF DEATH

14066

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural</b><br>c. LENGTH OF STAY IN 1b<br><b>1 day</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Alexandria</b> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Milton Howard DAVIS</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>October 28 1967</b>   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Cauc</b>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>26 October 1893</b>   |  |
| 9. AGE (In years last birthday)<br><b>74 yrs</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Musician</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Musician</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D. C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Edward Thomas DAVIS</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret BURKHARDT</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW 1</b>  |  | 16. SOCIAL SECURITY NO.<br><b>579-07-5720</b>  |  |
| 17. INFORMANT<br><b>Ruth V. DAVIS</b>   |  | 18. ADDRESS<br><b>5800 N. Flaxton Place Alexandria, Virginia</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral Brochopneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Generalized Arteriosclerotic Vascular Disease with Severe Arteriolonephrosclerosis and</b><br>DUE TO<br>(c) <b>Arteriosclerotic Heart Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (1) (this hospital) attended the deceased from <b>27 October, 1967</b> , to <b>28 October, 1967</b> , that (we) last saw the deceased alive on <b>28 October 1967</b> , and that death occurred at <b>2:35 P.M.</b> , from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE<br><i>David R. Foreman</i>   |  | 22b. DATE SIGNED<br><b>28 October 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>David R. FOREMAN LT MC USN</b>   |  | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>10-31-67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D. C.</b>  |  |
| 24. FUNERAL DIRECTOR<br><i>John W. P. Jones</i><br><b>Demaine Funeral Home Alexandria, Virginia</b>   |  | 25a. REC'D BY REGISTRAR<br><b>NOV 1 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |   |   |  |  |  |   |  |   |  |
|---|--|----------------------------------|---|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |   |   |  |  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |                                  |   |   |  |  |  |   |  |   |  |
| 14067   |  |                                  |   |   |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |                                  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |  |                                  |   |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>                                 |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>620 Saint Andrews Lane</u>   |  |                                  |   |   |  | d. STREET ADDRESS<br><u>620 Saint Andrews Lane</u>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARY</u> Middle <u>CHRISTINA</u> Last <u>DE NEANE</u>   |  |                                  |   |   |  | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>26</u> Year <u>1967</u>  |  |   |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>January 1, 1887</u>   |  | 9. AGE (in years last birthday)<br><u>80</u> yrs.                       |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>   |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>at home</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Washington, D.C.</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Richard Holt</u>  |  |                                  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Kathryn</u>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  |                                  |   | 16. SOCIAL SECURITY NO.<br><u>  </u>  |  | 17. INFORMANT<br><u>F. Edwin De Neane</u>  |  |   |  | Address<br><u>207 Indian St. S.E. Md</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>4<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cardio-Vascular Renal Disease</u><br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |                                  |   |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u><br><u>5 yrs</u>                       |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                  |   |   |  |  |  |   |  |   |  |
| MEDICAL CERTIFICATION   |  |                                  |   |   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |  |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                    |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>  </u> , to <u>Oct. 26</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/10</u> 19 <u>67</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.   |  |                                  |   |   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><u>Harold Heiges</u>  |  |                                  |   |   |  |  |  |   |  | 22b. DATE SIGNED<br><u>10/26/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Harold Heiges</u>  |  |                                  |   |   |  | 22d. ADDRESS<br><u>5415 Conn. Ave NW DC</u>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |                                  | 23b. DATE THEREOF<br><u>Oct. 28, 1967</u> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cemetery</u> |  |  | 23d. LOCATION (City, town or county) (State)<br><u>Washington, D.C.</u> |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Arthur Hillers</u>   |  |                                  |   |   |  | ADDRESS<br><u>254 Carroll St NW. Wash DC</u>   |  | 25. REC'D BY REGISTRAR<br><u>  </u>                                     |  | 26. REGISTRAR'S SIGNATURE<br><u>John B. Hill</u>                                      |  |
| DATE<br><u>OCT 27 1967</u>  |  |                                  |   |   |  | DATE<br><u>  </u>  |  |   |  |   |  |

Dr John B. Hill Not. Pub. & will approve Name of Heiges M.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                                  |  |                                    | 14068  |  |  |   |
|--|----------------------------------|--|------------------------------------|--|--|--|---|
| CERTIFICATE OF DEATH   |                                  |  |                                    |  |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                                  |  |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>P</u> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TAKOMA PARK</u>   |                                  | c. LENGTH OF STAY IN 1b  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>GREENBELT</u>                                 |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington SAN. &amp; Hosp</u>  |                                  |  |                                    | d. STREET ADDRESS<br><u>710 GREENBELT RD.</u>  |  | e. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Joseph LEE DEW</u>   |                                  |  |                                    | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>18</u> Year <u>1967</u>   |  |  |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>7-12-92</u> | 9. AGE (In years last birthday)<br><u>75</u> yrs   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bus Operator</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><u>?</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>Robert DEW</u>   |                                  |  |                                    | 14. MOTHER'S MAIDEN NAME<br><u>?</u> Unknown   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>578-10-5948</u>   |                                    | 17. INFORMANT<br><u>Mrs Mary E. Brown</u><br>Address <u>903 Seeks Lane, Silver Spring</u>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>DUE TO <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Carcinoma Prostate with</u><br>DUE TO <u>  </u><br>(c) <u>Widespread Bone metastases</u> |                                  |  |                                    |  |  |  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Bronchopneumonia</u>   |                                  |  |                                    |  |  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |                                    |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |                                  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not White <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    | 20e. PLACE OF INJURY (Home, farm, factory street, office bldg, etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>67</u> , to <u>10/18/67</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that death occurred at <u>1:25</u> PM, from causes on and on the date stated above.  |                                  |  |                                    |  |  |  |   |
| 22a. SIGNATURE<br><u>Joseph E. Smith, Jr. M.D.</u>   |                                  |  |                                    | 22b. DATE SIGNED<br><u>10/</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>Joseph E. Smith, Jr.</u>                                    |   |
| 22d. ADDRESS<br><u>4140 Sandy Spring Rd., Burtonsville, Md.</u>  |                                  |  |                                    |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>10/21/67</u>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>George Washington</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Prince George Co., Md.</u>                 |   |
| 24. FUNERAL DIRECTOR<br><u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u><br><u>Rockville, Md.</u>   |                                  |  |                                    | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 23 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>R Charles Judge</u>   |   |



CERTIFICATE OF DEATH

14069

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b<br><u>12 Days</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>  |  | e. STREET ADDRESS<br><u>809 Hobbs Drive</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Frank</u> Middle <u>James</u> Last <u>Dillon, Jr.</u>  |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>14</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>21 April 1924</u>   |
| 9. AGE (In years last birthday)<br><u>43</u> yrs  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Printer</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>West Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Frank J. Dillon, Sr.</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Thelma Ray</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u> <u>WW II</u>   |  | 16. SOCIAL SECURITY NO<br><u>236-28-9967</u>  |  |
| 17. INFORMANT<br><u>The Medical Records</u>   |  | 18. WHERE DECEASED<br><u>The Clinical Center, Bethesda, Maryland</u>  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia (R. Lung)</u><br>DUE TO<br>(b) <u>Acute Lymphocytic Leukemia</u><br>DUE TO<br>(c) <u></u>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 Days</u><br><u>8 Months</u>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>2 October, 1967</u> , to <u>14 October 1967</u> , that <u>X</u> (we) last saw the deceased alive on <u>14 October 1967</u> , and that death occurred at <u>8:55</u> M, from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><u>John W. Keyes, Jr.</u>   |  | 22b. DATE SIGNED<br><u>15 October 1967</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John W. Keyes, Jr., MD.</u>  |  | 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><u>Oct. 19, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Millersville Mennonite Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Millersville, Pennsylvania</u> |
| 24. FUNERAL DIRECTOR<br><u>C. Glen Carter</u>   |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1-1070

4065

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                      |   |   |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b<br><u>PARC</u>  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br>MARYLAND<br>b. COUNTY<br><u>Washington D.C.</u>        |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanatorium &amp; Hospital</u>  |                                      | d. STREET ADDRESS<br><u>4815 Illinois Ave. N.W.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>John Adams Dills</u>   |                                      | 4. DATE OF DEATH<br>Month Day Year<br><u>10 13 1967</u>   |   |
| 5. SEX<br><u>m</u>   | 6. COLOR OR RACE<br><u>white</u>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-26-95</u>  |
| 9. AGE (In years last birthday)<br><u>72</u> yrs   |                                      | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Gov't worker</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pennsylvania</u>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><u>Amer</u>   |   |
| 13. FATHER'S NAME<br><u>Samuel R Dills</u>   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Eva Adams</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>yes WWI-Army</u>  |                                      | 16. SOCIAL SECURITY NO.<br><u>579-50-254</u>  |   |
| 17. INFORMANT<br><u>BA Patient's Chart</u>   |                                      | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO (b) <u>Coronary Occlusion and Myocardial Infarction both old and recent</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |                                      |   | INTERVA. BETWEEN ONSET AND DEATH<br><u>Months</u><br><u>Months</u>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Early Pneumonia</u>   |                                      |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>  |                                      | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>    |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1966, to <u>October 13</u> , 1967, that (I) (we) last saw the deceased alive on <u>October 13</u> , 1967, and that death occurred at <u>2:39 PM</u> , from causes and on the date stated above.   |                                      |   |   |
| 22a. SIGNATURE<br><u>Stuart L. Nelson</u>  |                                      | 22b. DATE SIGNED<br><u>10-14-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Stuart L. Nelson</u>  |                                      | 22d. ADDRESS<br><u>7600 Carroll Ave. Takoma Park, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>removal</u>  | 23b. DATE THEREOF<br><u>10/15/67</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Indian Orchard Cem.</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Honesdale, Pa.</u>                            |
| 24. FUNERAL DIRECTOR<br><u>Free S. H. Hines</u>  |                                      | 25a. REC'D BY REGISTRAR<br><u>290-1476</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>William J. Judge</u>  |                                      | DATE<br><u>OCT 17 1967</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |
|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |
| 1-10-71  |  |  |   |  |  |
| 1 PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>...</u> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |  | c. LENGTH OF STAY IN lb<br><u>11 days</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hyattsville</u> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington JAN. &amp; Hosp</u>  |  |  | d. STREET ADDRESS<br><u>2215 Beechwood Rd.</u>  |  | e. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <u>Wilson</u> Middle <u>None</u> Last <u>DISNEY</u>   |  |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>16</u> Year <u>1967</u>  |  |  |
| 5 SEX<br><u>M</u>  | 6 COLOR OR RACE<br><u>W</u>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-20-00</u>  |  | 9. AGE (In years last birthday)<br><u>67</u> yrs   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Steel Company</u>  |   | 11 BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>                                  |  |
| 13. FATHER'S NAME<br><u>THALES DISNEY</u>  |  |  | 12 CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  |  | 16 SOCIAL SECURITY NO<br><u>577-05-7940</u>   |  |  |
| 17. INFORMANT<br><u>CHART</u>  |  |  | Address   |  |  |
| 1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u><br>DUE TO<br>(b) _____<br>DUE TO<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>11 days</u>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)   |   |  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19__   | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> , 19 <u>67</u> , to <u>10-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-15</u> , 19 <u>67</u> , and that death occurred at <u>1:30 PM</u> , from causes on and on the date stated above.    |  |  |   |  |  |
| 22a. SIGNATURE<br><u>W.B. Wardrop MD</u>   |  |  | 22b. DATE SIGNED<br><u>10-17-67</u>   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>W.B. WARDROP MD</u>   |  |  | 22d. ADDRESS<br><u>808 PERSHING Dr. Silver Spring Md</u>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>Oct 20, 1967</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park Cemetery</u>                                      |  |
| 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>   |  |  |   |  |  |
| 24 FUNERAL DIRECTOR<br><u>Francis Saccis Sons</u>  |  |  | ADDRESS<br><u>Hyattsville, Md</u>   |  | 25a REC'D BY REGISTRAR<br><u>OCT 20 1967</u>   |
|  |  |  | 25b REGISTRAR'S SIGNATURE<br><u>J Charles Judge</u>   |  |  |



4064

## CERTIFICATE OF DEATH

14072

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN TB <u>20 days</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>d. STREET ADDRESS <u>4607 Edgemoor Rd</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Gertrude Dacey</u><br>First Middle Last<br>4 DATE OF DEATH <u>Oct. 31 1967</u><br>Month Day Year  |  | 5 SEX <u>Female</u><br>6. COLOR OR RACE <u>White</u><br>7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8 DATE OF BIRTH <u>1/6/99</u><br>9 AGE (in years last birthday) <u>68</u><br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br>10b. KIND OF BUSINESS OR INDUSTRY<br>11 BIRTHPLACE (County & State, or foreign country) <u>Ohio</u><br>12 CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 13. FATHER'S NAME <u>John C Dacey</u><br>14 MOTHER'S MAIDEN NAME <u>Mary Ann Doyle</u>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u><br>16 SOCIAL SECURITY NO. <u>213-56-4878</u><br>17 INFORMANT <u>James Dacey (son)</u><br>Address <u>8607 Pennsylvania St. Silver Spring, Md.</u>  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO <u>Coronary insufficiency</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Coronary insufficiency</u><br>DUE TO<br>(c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of left breast. Pneumonia.</u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) <u>None</u><br>20c TIME OF INJURY Month, Day Year<br>Hour a.m. _____ p.m. <u>19</u><br>20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f (City or town) (County) (State) |  | 21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>65</u> , to <u>present</u> , that (I) (we) last saw the deceased alive on <u>10/29/67</u> , and that death occurred at <u>home</u> from causes and on the date stated above.<br>22a. SIGNATURE <u>John B. Umhau</u><br>22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU MD.</u><br>22d. ADDRESS <u>8805 CONN. AVE. CHESAPE, MD.</u><br>22b. DATE SIGNED <u>11/1/67</u><br>M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u><br>23b. DATE THEREOF <u>11-3-67</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u><br>23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>  |  | 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u><br>25a REC'D BY REGISTRAR <u>NOV 2 1967</u><br>25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1073

|   |  |   |   |
|---|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |  | d. STREET ADDRESS <u>4822 - Cherry Chase</u>  |   |
| 3 NAME OF DECEASED (Type or print) <u>Frank J. Donahue</u>  |  | 4 DATE OF DEATH <u>Oct. 23 1967</u>   |   |
| 5 SEX <u>Male</u>   | 6 COLOR OR RACE <u>White</u>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>7/26/85</u>  |
| 9. AGE (In years last birthday) <u>82</u> yrs   |  | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Gas Light Co.</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13 FATHER'S NAME <u>James Donahue</u>   |  | 14 MOTHER'S MAIDEN NAME <u>Sarah Egan</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>   |  | 16 SOCIAL SECURITY NO <u>57707-4920A</u>  |   |
| 17 INFORMANT <u>Mrs. Constance D. Fletcher</u>  |  | Address <u>5648 - 14th St. NW, Arlington, VA</u>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>1916<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Squamous cell carcinoma skin of thumb with</u><br>(c) <u>diffuse metastasis.</u>  |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>Years -</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE <u>John S. Bell</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>John S. Bell</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/24/67</u>   |   |
|   |  | Address (Street, city, town, or county)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>10-26-1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Glewood Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>                         |
| 24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W.</u>  |  | 25a. REC'D BY REGISTRAR <u>OCT 26 1967</u>  |   |
| ADDRESS <u>Wash. D.C.</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |

22 DATE SIGNED





## CERTIFICATE OF DEATH

1-1074

4863

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN TB<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Saint Hosp</u> |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>Georgia Ave &amp; Blair</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Douglas F. Dorton</u>   |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>19</u> Year <u>1967</u>   |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>2-19-1902</u>             |
| 9a. AGE (In years last birthday) <u>65</u> yrs.   |  | 9b. IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>19</u> Hours <u>67</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER'S HELPER</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Giant Food Co.</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>William H. Dorton</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Rosa Hurd</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>   |  | 16. SOCIAL SECURITY NO   |   |
| 17. INFORMANT <u>Wife</u>   |  | Address <u>SAME</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Lt. Ventricular Failure</u><br>DUE TO<br>(b) <u>Aortic stenosis</u><br>DUE TO<br>(c) <u>(Possible) Rheumatic valvulitis</u>                            |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hrs</u><br><u>5 yrs</u><br><u>Chronic</u>   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)          |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>10-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-13</u> , 19 <u>67</u> , and that death occurred at <u>12</u> A.M., from causes and on the date stated above. |  |  |   |
| 22a. SIGNATURE <u>R. L. Sengstack M.D.</u>  |  | 22b. DATE SIGNED <u>10-19-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>George F. Sengstack</u>   |  | 22d. ADDRESS <u>9241 Columbia Blvd. Silver Springs, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION (City or Town) (County) (State) |
| <u>Burial</u>   | <u>10/21/67</u>  | <u>Monte Vesta</u>   | <u>Mercer County W. Va.</u>                   |
| 24. FUNERAL DIRECTOR <u>Bene. Ryan, Jr.</u>   |  | 25a. REC'D BY REGISTRAR  |   |
| <u>Arlington Funeral Home</u>   |  | <u>3901 No. Fairfax Dr. Arlington, Virginia</u>  |   |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  | DATE <u>OCT 23 1967</u>  |   |

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 4. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

14075

|   |  |  |   |   |   |
|---|--|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>  |  | c. LENGTH OF STAY IN 1b<br><b>2 days</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Triangle</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>   |  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Kelly Anne DOUDS</b>   |  | 4. DATE OF DEATH<br>Month<br><b>October</b><br>Day<br><b>25</b><br>Year<br><b>19 67</b>  |   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Cauc</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 22 1967</b>                                     | 9. AGE (In years last birthday)<br><b>3</b> yrs   | IF UNDER 1 YEAR<br>Months<br><b>3</b><br>Days<br><b>3</b><br>Hours<br><b>3</b><br>Min<br><b>3</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>N/A</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Quantico, Virginia</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |   |   |   |
| 13. FATHER'S NAME<br><b>John C. Douds</b>   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Delfina Marie Hocho</b>                      |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>N/A</b>   |  | 16. SOCIAL SECURITY NO<br><b>N/A</b>   |   | 17. INFORMANT<br><b>Hospital records</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis, bilateral</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO<br>(c) _____ |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)   | (County)  | (State)   |
| 21. I certify that (A) (this hospital) attended the deceased from <b>Oct. 23</b> , 1967, to <b>Oct 25</b> , 1967, that (B) (we) last saw the deceased alive on <b>Oct. 25</b> , 1967, and that death occurred at <b>1230 A.M.</b> from causes and on the date stated above.                                   |  |  |   |   |   |
| 22a. SIGNATURE<br><i>Gene P. Swartz, M.D.</i>   |  | 22b. DATE SIGNED<br><b>Oct. 26, 1967</b>   |   | 22c. PHYSICIAN'S NAME (Type)<br><b>Gene P. Swartz, M. D.</b>  |   |
| 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Maryland</b>   |  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10/27/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington, Virginia</b> |   |   |
| 24. FUNERAL DIRECTOR<br><b>Everly-Wheeler Funeral Home</b>  |  | 25a. REC'D BY REGISTRAR<br><b>OCT 30 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G39J 11/13/67 ph

CERTIFICATE OF DEATH

1-1076

|   |                              |   |                                       |
|---|------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Mont.</u> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>MONTG.</u>                        |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |                                       |
| c. LENGTH OF STAY IN lb<br><u>85 days</u>   |                              | d. STREET ADDRESS<br><u>7713 Eastern Ave.</u>   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Randolph Hills Nursing Home</u><br><u>4001 Randolph Road</u>   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Rachel (RAY)</u>   |                              | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>16</u> Year <u>1967</u>  |                                       |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-28-1885</u> |
| 9. AGE (years, months, days)<br><u>82</u> yrs   |                              | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                       |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>INS WIFE</u>  |                              | 11. BIRTHPLACE (County & State or foreign country)<br><u>NEW YORK</u>   |                                       |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                              | 13. FATHER'S NAME<br><u>(UNKNOWN) Levy</u>  |                                       |
| 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |                              | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>                                     |                                       |
| 16. SOCIAL SECURITY NO.   |                              | 17. INFORMANT<br>Address<br><u>HERBERT A. DUKE, SR. BETHESDA, MD.</u>   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ARTERIOSCLEROSIS</u><br>DUE TO<br>(c) |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>17 HOURS</u>   |                                       |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>FRACTURE HIP - GUNSHOT BRAWN D STAKE</u>   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>NO</u>   |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> o.m.<br>p.m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>10-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-4</u> , 19 <u>67</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above   |                              |   |                                       |
| 22a. SIGNATURE<br><u>Lester S. Blumenthal MD</u>  |                              | 22b. DATE SIGNED<br><u>10-16 67</u>   |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><u>LESTER S. BLUMENTHAL</u>   |                              | 22d. ADDRESS<br><u>5315 CONN AVE NW</u>   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                              | 23b. DATE THEREOF<br><u>10/18/67</u>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>KING DAVID</u>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><u>FALL CHURCH VA.</u>   |                                       |
| 24. FUNERAL DIRECTOR<br><u>Joe. Lawler's Land Inc. Wash. D.C.</u>   |                              | 25a. REC'D BY REGISTRAR<br><u>OCT 19 1967</u>   |                                       |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                              |   |                                       |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14077

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u> |  |
| c. LENGTH OF STAY IN 1b <u>DoA</u>  |  | d. STREET ADDRESS <u>Box 123</u>   |  |
| e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3 NAME OF DECEASED (Type or print)<br>First <u>Eric</u> Middle <u>Michael</u> Last <u>Duvall</u>  |  | 4 DATE OF DEATH<br>Month <u>Oct</u> Day <u>29</u> Year <u>1967</u>   |  |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>Negro</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>MAR. 25, 1967</u>   |
| 9. AGE (In years last birthday) yrs <u>7</u> Months <u>3</u>  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>3</u> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>                                      |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  | 13. FATHER'S NAME <u>George Duvall</u>   |  |
| 14. MOTHER'S MAIDEN NAME <u>Rosalie Clipper</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NONE</u>  |  |
| 16. SOCIAL SECURITY NO. <u>NONE</u>   |  | 17. INFORMANT <u>Rosalie Duvall item # 2 (Mother)</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not White <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>John S. Bell</u> M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/29/67</u>  |  |
|   |  | Address (Street, city, town, or county)  |  |
| 22. DATE SIGNED   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION (City or town) (County) (State)  |
| <u>BURIAL</u>   | <u>OCT. 31, 1967</u>   | <u>Seneca Cemetery</u>   | <u>Seneca Montg. Md.</u>   |
| 24. FUNERAL DIRECTOR  | ADDRESS  | 25a. REC'D BY REGISTRAR  | 25b. REGISTRAR'S SIGNATURE   |
| <u>Robert L. Snowden</u>  | <u>Rockville, Md.</u>  | <u>NOV 6 1967</u>  | <u>Charles Judge</u>   |





14873

## CERTIFICATE OF DEATH

14078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |   |
| c. LENGTH OF STAY IN 1b <u>3 yrs.</u>   |   | d. STREET ADDRESS <u>10210 GLEN Rd.</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10210 GLEN Rd.</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>MARY</u>   |   | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1967</u>  |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 13, 1883</u>                                    |
| 9. AGE (In years lost birthday) <u>84</u> yrs   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Czechoslovakia</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>  |   |
| 13. FATHER'S NAME <u>Bartholomew Soukup</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Mary Kolar</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>Unknown</u>   |   |
| 17. INFORMANT <u>Daughter</u>   |   | Address <u>Same as Item 2.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>                |   | INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u><br><u>15 YRS</u><br><u>30 YRS</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |  |   |
| 19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>64</u> to <u>Oct 17</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/13, 1967</u> , and that death occurred at <u>4:20 A.M.</u> from causes and on the date stated above. |   |  |   |
| 22a. SIGNATURE <u>W. G. Hall</u>  |   | 22b. DATE SIGNED <u>10/17/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>W. G. HALL</u>  |   | 22d. ADDRESS <u>615 W. Montgomery Ave. Rockville, Maryland</u>   |   |
| 23a. BURIAL CREMATION, REMOVA. (Specify) <u>Cremation</u>   | 23b. DATE THEREOF <u>10-20-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |   | 25a. REC'D BY REGISTRAR <u>DATE OCT 20 1967</u>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE <u>Attestable Judge</u>   |   |

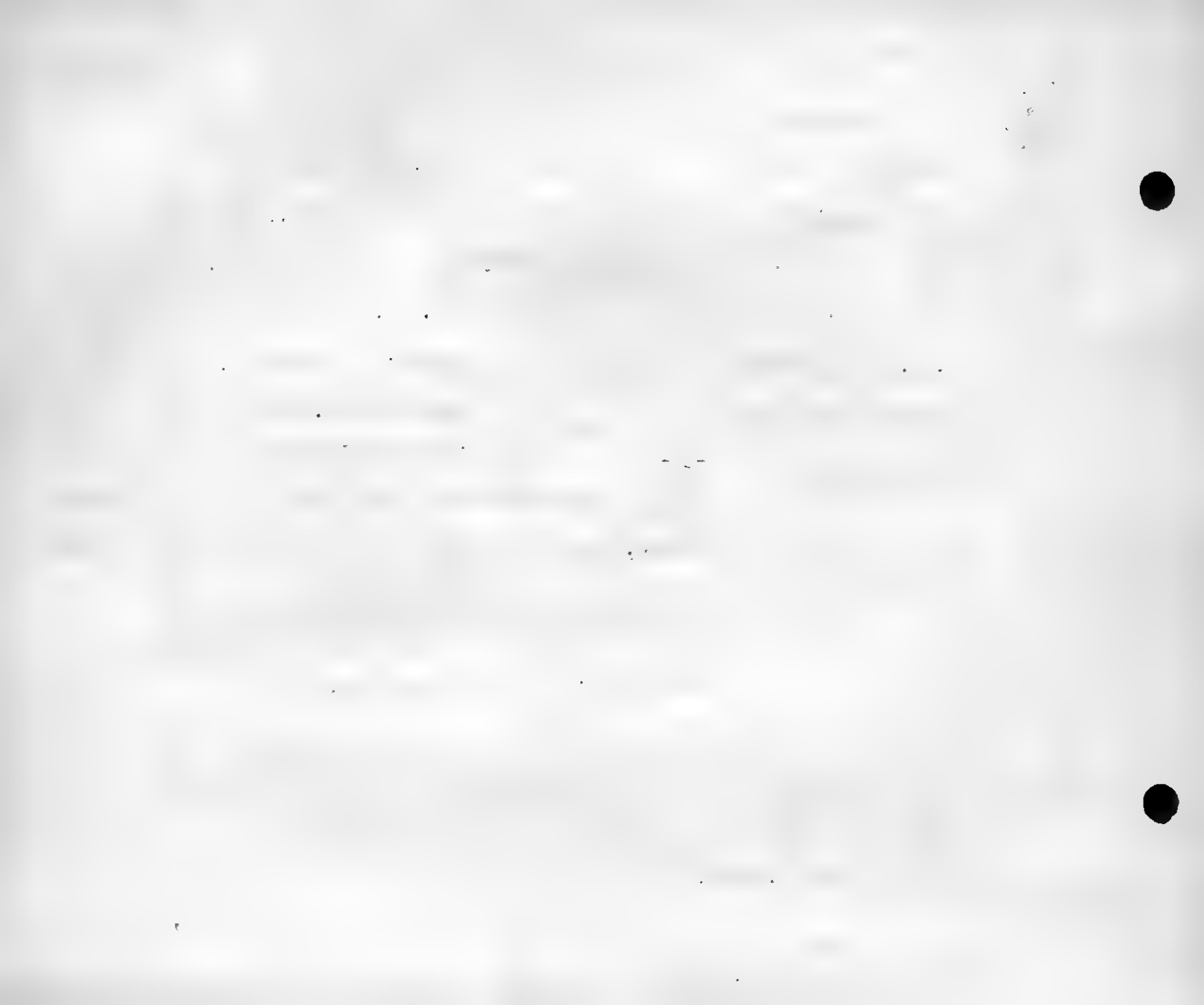


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| Item 20 Film 394 10-31-67 MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                |   |  |  |   |  |  |   |  |
|---|--|--------------------------------|---|--|--|---|--|--|---|--|
| 1074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                |   |  | 14079  |   |  |  |   |  |
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |                                |   |  | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <b>Ohio</b> b. COUNTY |   |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>   |  |                                | c. LENGTH OF STAY IN TB<br><b>10 Days</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>North Lawrence</b>            |   |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>   |  |                                |   |  | d. STREET ADDRESS<br><b>1148 Glenway Ave., Northwest</b>   |   |  |  |   |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Allen</b> Last <b>EVANOVICH</b>  |  |                                |   |  | 4 DATE OF DEATH<br>Month <b>Oct.</b> Day <b>12</b> Year <b>67</b>  |   |  |  |   |  |
| 5 SEX<br><b>Male</b>  |  | 6 COLOR OR RACE<br><b>Cauc</b> |   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br><b>Sept. 19, 1943</b>  |  | 9 AGE (in years lost birthday) yrs <b>24</b>                           |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U. S. Marine Corps</b>  |  |                                |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Franklin, Tuscarawas, Ohio</b>          |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |   |  |
| 13. FATHER'S NAME<br><b>Michael Frank Evanovich</b>   |  |                                |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth M. (Not Known)</b>  |   |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 2-20-64 to 10-12-67</b>   |  |                                |   |  | 16. SOCIAL SECURITY NO.<br><b>276 38 0596</b>  |   |  |  |   |  |
| 17. INFORMANT<br><b>Marine Corps Records</b>  |  |                                |   |  | Address  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Hemorrhage from Aortic Aneurysm</b><br>DUE TO<br>(b) <b>Trauma, Auto Accident</b><br>DUE TO<br>(c)  |  |                                |   |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>40 Days</b>                               |  |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                |   |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Passenger in auto involved in accident</b>                |  |   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>1:20 Hour a.m. 9-4 19 67</b>   |  |                                |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work                                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Street</b> |  | 20f. (City or town) (County) (State)<br><b>Charlestown South Caro.</b> |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                                |   |  |  |   |  |  |   |  |
| ACTUAL SIGNATURE <b>John G. Ball</b> MD   |  |                                |   |  | 22. DATE SIGNED<br><b>10/13/67</b>   |   |  |  |   |  |
| EXAMINER'S NAME (Type)<br><b>John G. Ball, MD</b>   |  |                                |   |  | Address (Street, city, town or county)   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>10-18-67</b>  |  |                                | 23b. DATE THEREOF<br><b>10-18-67</b>      |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brookfield Cemetery</b>                        |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Massillon, Ohio</b>                           |  |
| 24. FUNERAL DIRECTOR<br><b>Falls Church Funeral Home, 1102 West Broad Street, Falls Church, Virginia</b>  |  |                                |   |  |  | 25a. REC'D BY REGISTRAR<br><b>OCT 17 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b><br>c. LENGTH OF STAY IN 1b<br><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>University Nursing Home</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Washington, D.C.</b><br>b. COUNTY<br><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>1826 Vernon Street, NW</b><br>d. STREET ADDRESS<br><b>as above</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Mattie Marie Fairfax</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>October 20 19 67</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2/2/1897</b>  |
| 9. AGE (In years last birthday)<br><b>70 yrs.</b>   |   | 10. FUND 1 YEAR<br>Months Days Hours Mln.   | 11. FUND 24 HRS.<br>Months Days Hours Mln.                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Practical nurse</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><br>11. BIRTHPLACE (County & State, or foreign country)<br><b>Warrenton, Va.</b>   |  |
| 13. FATHER'S NAME<br><b>Andrew Williams</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><br>17. INFORMANT<br><b>Nursing Home Records</b><br>Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>H. U. hemorrhage due to renal disease</b><br>DUE TO (b) <b>discrete</b><br>DUE TO (c) <b>nephrosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>arteriosclerotic heart disease; diabetes mellitus</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>13 Oct 1967</b> to <b>20 Oct 1967</b> that (I) (we) last saw the deceased alive on <b>18 Oct 1967</b> and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>Emerson Williams</b><br>M.D.   |   | 22b. DATE SIGNED<br><b>10-20-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Emerson Williams, M.D.</b>   |   | 22d. ADDRESS<br><b>705 Kenyon St., NW, Wash., DC</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10/24/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Warrenton</b>  | 23d. LOCATION (City, town or county) (State)<br><b>Warrenton, Virginia</b> |
| 24. FUNERAL DIRECTOR<br><b>Moser Funeral Home Warrenton Va</b><br>ADDRESS   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 23 1967</b><br>DATE   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

- CLEARED BY DR. REAP

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>  |  | c. LENGTH OF STAY IN 1b <b>11 days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>  |  | d. STREET ADDRESS <b>3603 Isbell Street</b>  |  |
| 3 NAME OF DECEASED<br>(Type or print) <b>HENRIETTE B. FEINBERG</b>   |  | 4. DATE OF DEATH <b>11:40 AM 10/27/1967</b>  |  |
| 5 SEX <b>F</b>   |  | 6. COLOR OR RACE <b>CAUC.</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>1/10/86</b>  |  |
| 9 AGE (in years last birthday) <b>81 yrs.</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>                            |  |
| 11 BIRTH PLACE (County & State, or foreign country) <b>New York N.Y.</b>   |  | 12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13 FATHER'S NAME <b>William F. Berkowitz</b>   |  | 14 MOTHER'S MAIDEN NAME <b>Frances Ehrlich</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16 SOCIAL SECURITY NO. <b>218 - 38-8040</b>  |  |
| 17 INFORMANT <b>Mrs. Sidney Faber</b>  |  | Address <b>3603 Isbell Sr. S.S. Md.</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>1538</b><br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b><br>DUE TO (b) <b>Bilateral bronchopneumonia</b><br>DUE TO (c) <b>Carcinoma of colon with widespread visceral &amp; skeletal metastases</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BLTG <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work                                  |  |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/16/67</b> , to <b>10/27, 1967</b> , that (I) (we) last saw the deceased alive on <b>10-27 1967</b> , and that death occurred at <b>11:40 AM</b> , from causes and on the date stated above.  |  |  |  |
| 22a SIGNATURE <b>Henry W. Jaeger</b>   |  | 22b DATE SIGNED <b>10/28/67</b>  |  |
| 22c PHYSICIAN'S NAME (Type) <b>Henry W. Jaeger</b>   |  | 22d ADDRESS <b>1015 Spring St., Silver Spring, Md.</b>   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>  |  | 23b. DATE THEREOF <b>Oct. 30, 1967</b>   |  |
| 23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>   |  | 23d LOCATION (City or Town) (County) (State) <b>Prince Georges County Md.</b>  |  |
| 24 FUNERAL DIRECTOR <b>John B. Thomas</b>  |  | 25a REC'D BY REGISTRAR <b>NOV 2 1967</b>   |  |
| 25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  | 25c ADDRESS <b>8434 Georgia Ave S.S.</b>   |  |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14082

|  |                                       |  |   |
|--|---------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                       | 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>                               |                                       | c. LENGTH OF STAY in 1b <u>16 days</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>                                   |                                       | d. STREET ADDRESS <u>7347 Wisconsin Ave -</u>  |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>JOHN</u> Middle <u>HENRY</u> Last <u>FISCHER SR</u>                             |                                       | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>11</u> Year <u>1967</u>  |   |
| 5 SEX <u>M</u>   | 6 COLOR OR RACE <u>W</u>              | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH <u>July 13 1904</u> 63 yrs                                      |
| 10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAXI DRIVER</u>                       |                                       | 10b. KIND OF BUSINESS OR INDUSTRY <u>577-50-6727</u>   | 9 AGE (In years last birthday) <u>63</u>  |
| 11 BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>  |                                       | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13 FATHER'S NAME <u>JOHN HENRY FISCHER SR.</u>   |                                       | 14. MOTHER'S MAIDEN NAME <u>MARY AGNES CODY</u>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>               |                                       | 16 SOCIAL SECURITY NO. <u>MARY AGNES CODY SR.</u>  |   |
| 17 INFORMANT <u>JOHN H FISCHER SR</u> Address <u>4812 Rockford Dr Hyattsville MD</u>   |                                       | 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction, posterior</u><br>DUE TO (b) <u>Coronary arteriosclerosis with occlusion</u><br>DUE TO (c) <u>Cerebral contusion + Fracture. Left H. H.</u><br>Interval between ONSET AND DEATH <u>2 days</u><br><u>16 days</u>   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) |                                       | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH    |                                       | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)<br><u>Shot self in head - and fell causing fracture of left hip</u>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>9:30</u> AM <u>PM</u> <u>9/23</u> 19 <u>67</u>                                 |                                       | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work  | 20e. PLACE OF INJURY (Home farm factory, street, office bldg, etc.) <u>Home</u> |
| 20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>MD</u>   |                                       | 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |
| ACTUAL SIGNATURE <u>John A. Ball</u> M.D.  |                                       | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <u>John A. Ball</u>   |                                       | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |                                       | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/11/67</u>  |   |
|  |                                       | Address (Street, city, town, or county)  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 23b. DATE THEREOF <u>16 OCT. 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>   | 23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>            |
| 24 FUNERAL DIRECTOR <u>U. W. CHAMBERS CO</u>   |                                       | 25a. REC'D BY REGISTRAR <u>SILVER SPRING, MD</u>   |   |
|  |                                       | 25b. REGISTRAR'S SIGNATURE <u>John A. Ball</u>   |   |
|  |                                       | 26. DATE SIGNED <u>OCT 18 1967</u>   |   |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14083

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b><br>c. LENGTH OF STAY IN 1b<br><b>DOA</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SUBURBAN</b>   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ROCKVILLE 20852</b><br>d. STREET ADDRESS<br><b>10201 GROSSMANOR PLACE #972</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>GEORGE M FISHER</b>  |  | 4 DATE OF DEATH<br>Month Day Year<br><b>OCT. 29 1967</b>  |  |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>WHITE</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>AUG 6, 1896</b>                           |
| 9 AGE (In years last birthday)<br><b>71</b> yrs  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BANKER</b>  | 10b. KIND OF BUSINESS OR INDUSTRY                                |
| 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>W. WILLIS FISHER</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY QUIGLEY</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES 1st WW</b>   |  | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>ELSIE FISHER - WIFE - SAME</b>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Abdominal aneurysm, ruptured</b><br><b>451X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <b>arteriosclerosis</b> DUE TO<br>(c) _____  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 years</b>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   | 20f. (City or town) (County) (State)                             |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><b>John E. Ball</b> M.D.   |  | 22. DATE SIGNED<br><b>10/30/67</b>  |  |
| EXAMINER'S NAME (Type)<br><b>John E. Ball</b>  |  | 22b. DEPT. OF HEALTH SIGNATURE<br><b>John E. Ball</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>Nov. 2-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Md</b>  |  | 25a. REC'D BY REGISTRAR<br><b>NO. 1 1967</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Simmons Bros.</b><br>Address<br><b>1661-Good Hope Rd SE Wash DC</b>   |  | 25b. REC'D BY REGISTRAR<br><b>John E. Ball</b>  |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

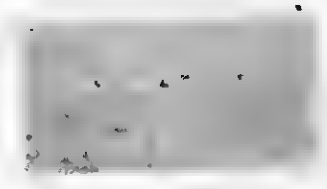
14084

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>(a) <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>WILLIAM</u> Middle <u>THOMAS</u> Last <u>FISHER</u>  |                                      | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>17</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>5-18-16</u>                                       |
| 9. AGE (In years last birthday)<br><u>51</u> yrs  |                                      | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>INSURANCE SALESMAN</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>ILLINOIS</u>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>FRANK L. FISHER</u>   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>FLORENCE STONE</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |                                      | 16. SOCIAL SECURITY NO<br><u>579-05-4381</u>   |  |
| 17. INFORMANT<br><u>OFFICER HRAPCHAK</u>  |                                      | Address<br><u>WHEATON STATION POLICE</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Gunshot wound in head</u><br>DUE TO (b) <u>with cerebral laceration</u><br>DUE TO (c) <u>and Exsanguination</u>  |                                      | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH<br><input checked="" type="checkbox"/>   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><u>Deceased, depressed, shot self in head while in auto in front of home</u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br><u>3:00 PM 10-17-1967</u>   |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.)<br><u>Street</u>  |                                      | 20f. (City or town) (County) (State)<br><u>Rockville Montgomery Md</u>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                      |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><u>BELDEN R. REAP</u>   |                                      | 22. DATE SIGNED<br><u>10/17/1967</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>10/19/67</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek</u>  | 23d. LOCATION (City or town) (County) (State)<br><u>Washington, D.C.</u> |
| 24. FUNERAL DIRECTOR<br><u>Wynson Wheeler Funeral Home</u>  |                                      | 25a. REC'D BY REGISTRAR<br><u>OCT 20 1967</u>  |  |
| Address<br><u>431 Rock Pike Rockville, Md.</u>  |                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14085

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b> b. COUNTY<br><b>PRINCE GEORGE'S</b>     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>  |   | c. LENGTH OF STAY IN TB<br><b>DOA</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>   |   | e. STREET ADDRESS<br><b>1432 UNIVERSITY BLVD.</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>AUSTIN Elton E. FLUENT</b>  |   | 4 DATE OF DEATH<br>Month Day Year<br><b>OCTOBER 16 1967</b>  |   |
| 5 SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>1-14-07</b>   |
| 9 AGE (in years last birthday)<br><b>60</b> yrs   |   | F UNDER 1 YEAR<br>Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BARBER</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Barbering</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MAINE</b>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>CLARENCE FLUENT</b>   |   | 14 MOTHER'S MA DEN NAME<br><b>ALICE Unknown</b>  |   |
| 15 WAS DECEASED EVER U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No No</b>  |   | 16 SOCIAL SECURITY NO<br><b>001-14-6315</b>  |   |
| 17 INFORMANT<br><b>WIFE</b>   |   | 18 ADDRESS<br><b>1432 University Blvd. Hyattsville, Md.</b>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>DUE TO (b) <b>Arteriosclerotic Heart &amp; Disease</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg etc)  | 20f. (City or town) (County) (State)  |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP</b>  |   | 22. DATE SIGNED<br><b>10/17/1967</b>   |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>  | 23b. DATE THEREOF<br><b>Oct. 17, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Port Lincoln Crematory</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Prince Georges Co., Md.</b> |
| 24 FUNERAL DIRECTOR<br><b>Clark &amp; Wison</b>   |   | 25a. RECD BY REG STRAR<br><b>Charles Judge</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   | DATE<br><b>OCT 19 1967</b>   |   |

24 FUNERAL DIRECTOR  
**Clark & Wison**  
8434 Annapolis Avenue  
Silver Spring, Md.

25a. RECD BY REG STRAR  
**Charles Judge**  
25b. REGISTRAR'S SIGNATURE  
**Charles Judge**  
DATE  
**OCT 19 1967**





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1-1086

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b> 15-1  |   |
| c. LENGTH OF STAY IN 1b<br><b>years</b>   |  | d. STREET ADDRESS<br><b>7116 Exfair Road</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>7116 Exfair Road</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>CORA</b> Middle <b>FOULKE</b> Last <b>FOULKE</b>   |  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>4</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 26, 1980</b>  |
| 9. AGE (In years lost birthday) yrs.<br><b>86</b>   |  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>19</b> Hours <b>07</b> Min   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Penna.</b>                              |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  | 13. FATHER'S NAME<br><b>George Gardner</b>  |   |
| 14. MOTHER'S MAIDEN NAME  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>                                     |   |
| 16. SOCIAL SECURITY NO.<br><b>One</b>   |  | 17. INFORMANT <b>Daughter</b> Address<br><b>Jean E. Foulke Same as Item 2.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF GALL BLADDER</b><br>DUE TO<br>(b) <b>WITH METASTASES TO LIVER</b><br>DUE TO<br>(c) <b>1551</b>                       |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YR</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>am</b> <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not White <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 1967</b> to <b>OCT. 4, 1967</b> , that (I) <del>(was)</del> <b>saw the deceased alive on Oct. 4, 1967</b> , and that death occurred at <b>12 P.M.</b> from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><b>Leo M. Curtis</b>  |  | 22b. DATE SIGNED<br><b>10-5-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>LEO CURTIS</b>   |  | 22d. ADDRESS<br><b>8218 Wisconsin Ave. Bethesda, Maryland</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10-7-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Rock's Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Lewistown, Penna.</b>                         |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 16 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

1-1087

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WHEATON</b><br>c. LENGTH OF STAY in 1b<br><b>15 days</b>  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>WASHINGTON, DC.</b><br>b. COUNTY<br><b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WASHINGTON</b><br>d. STREET ADDRESS<br><b>4201 MASS.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>EARL BENNETT FRANK</b>   |  | 4 DATE OF DEATH<br>Month <b>10</b> Day <b>25</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>NOV 21 1893</b><br>9. AGE (In years last birthday) <b>73</b> yrs                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>DENTIST</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>DENTIST</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>RHODE ISLAND</b><br>12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |
| 13. FATHER'S NAME<br><b>CRAWFORD PHILIP FRANK</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>AUGUSTA CHAMPLIN</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES W.W.I.</b>  |  | 16. SOCIAL SECURITY NO<br><b>579-60-3344T</b><br>17. INFORMANT<br><b>CATHERINE T. FRANK, WIFE, SAME AS #2</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br>DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>4 yrs</b><br><b>Serial years</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10/25/67</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diverticulitis - abscess formation - Colonotomy in Aug 1967</b>  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>ALSO HAD EMPHYSEMA.</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August, 1960</b> to <b>10/25, 1967</b> that (I) (we) last saw the deceased alive on <b>10/24 1967</b> , and that death occurred at <b>9:55 AM</b> , from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE<br><b>R. S. Williams</b>  |  | 22b. DATE SIGNED<br><b>10/25/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>R. S. WILLIAMS</b>  |  | 22d. ADDRESS<br><b>35 NEW YORK AVE. NW.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>10/28/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN CEM.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BLADENSBURG, MD.</b>  |
| 24. FUNERAL DIRECTOR<br><b>JOS. GAWLER'S SONS, 5130 WIS. AVE. NW, WASH., D.C.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DATE NOV 1 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14088

4083

FOR STATE HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                               | c. LENGTH OF STAY IN 1b <u>SOA</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <u>Daniel Herman Franks</u>  |                               | 4. DATE OF DEATH <u>October 3 1967</u>  |   |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>January 22-1914</u> |
| 9. AGE (in years last birthday) <u>53</u> yrs  |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tax Attorney</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Cleveland - Ohio</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13. FATHER'S NAME <u>MORRIS FRANKS</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Unknown -</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> <u>WW II</u>   |                               | 16. SOCIAL SECURITY NO. <u>293-01-8609</u>  |   |
| 17. INFORMANT <u>Mrs Daniel Franks</u>   |                               | Address <u>Above</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |                               |   |   |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>   |                               |   |   |
| DUE TO <u>Coronary arteriosclerosis with occlusion</u>   |                               |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____   |                               |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                               |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |   |
| 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. _____ 19  |                               | 20d. INJURY OCCURRED While of work <input type="checkbox"/> not While of work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)   |                               | 20f. (City or town) (County) (State)  |   |
| 21. I certify that took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |   |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D.  |                               | 22. DATE SIGNED <u>Oct 4, 1967</u>  |   |
| EXAMINER'S NAME (Type) _____   |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) |   |
| 23a. BURIAL CREMATION (Burial) <input checked="" type="checkbox"/> (Cremation) <input type="checkbox"/>  |                               | 23b. DATE OF BURIAL <u>10/8/67</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>ZION MEM. PARK</u>   |                               | 23d. LOCATION (City or Town) (County) (State) <u>BEDFORD OHIO</u>   |   |
| 23e. FLNERA. DIRECTOR <u>Goetzberg Funeral Home</u>  |                               | 23f. REC'D BY REGISTRAR <u>1967</u>   |   |
| 23g. ADDRESS <u>4217 9th Ave</u>   |                               | 23h. REGISTRAR'S SIGNATURE <u>James Judge</u>   |   |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

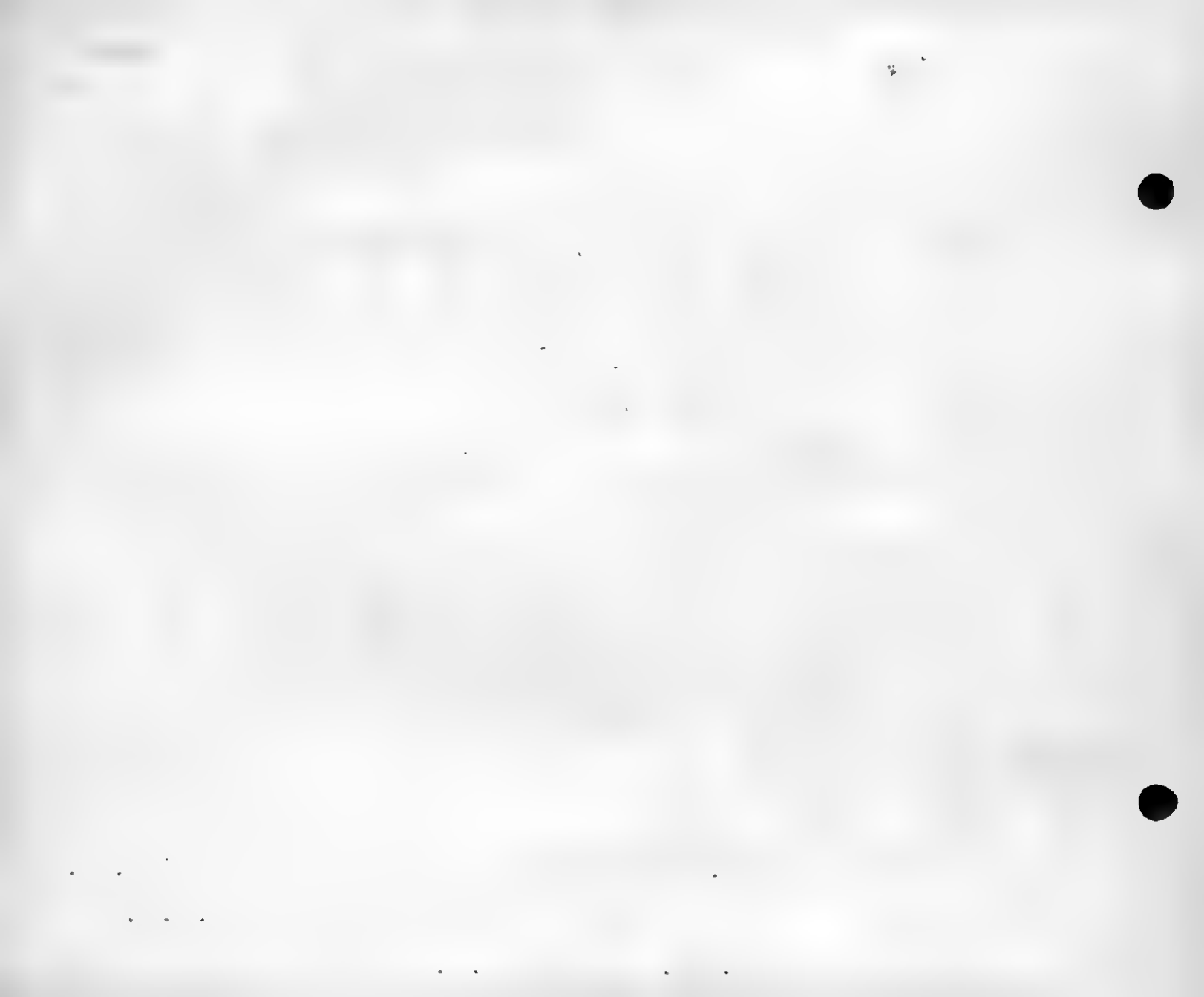
14089

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b <u>D.O.A.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  | d. STREET ADDRESS <u>3301 Cummings Lane</u>  |  |
| 3 NAME OF DECEASED (Type or print) <u>John</u> First Middle <u>Carlos</u> <u>FRANZONI</u>  |  | 4 DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1967</u>   |  |
| 5. SEX <u>M.</u>   | 6. COLOR OR RACE <u>W.</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 15, 1908</u>  |
| 9. AGE (In years last birthday) <u>59</u> yrs  |  | IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tech. Assist.</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Reserve Gov.</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Fred. Royce Franzoni</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Bessie Jones</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>   |  | 16. SOCIAL SECURITY NO   |  |
| 17. INFORMANT <u>Kathryn Franzoni wife</u>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - Acute -</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease -</u><br>DUE TO (c)   |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u><br><u>Years</u>                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> - NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month Day, Year<br>Hour o m p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D.  |  | 22. DATE SIGNED <u>10/8/67</u>   |  |
| EXAMINER'S NAME (Type) <u>John G. Ball</u>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bethesda, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>10/11/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>                           |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Washington, D. C.</u>  |  | 25a. REC'D BY REGISTRAR <u>OCT 10 1967</u>   |  |
| ADDRESS  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |









4085

## CERTIFICATE OF DEATH

14091

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared with Dr. Reap / Medical Examiner at 3:00PM 10/13/67

|   |   |   |  |
|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |   | c. LENGTH OF STAY IN 1b<br><b>4 hours</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>  |   | d. STREET ADDRESS<br><b>10425 Balt. Ave.</b>  |  |
| 3 NAME OF DECEASED (Type or print)<br><b>Lucretia D. Gano</b>   |   | 4. DATE OF DEATH<br>Month <b>10-13</b> Day <b>19</b> Year <b>67</b>   |  |
| 5 SEX<br><b>f</b>   | 6 COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>10-27 5-23-67</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>West Va</b>  |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  |
| 13 FATHER'S NAME<br><b>William C Daniels</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Betty H. Hendricks</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |   | 16 SOCIAL SECURITY NO<br><b>214 48 6160</b>   |  |
| 17 INFORMANT<br><b>Marion E Gano</b>  |   | Address<br><b>Beltsville, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br>DUE TO (b) <b>Acute myocardial infarction</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-2</b> , 19 <b>67</b> , to <b>10-13</b> , 19 <b>67</b> ; that (I) (we) last saw the deceased alive on <b>10-13</b> 19 <b>67</b> and that death occurred at <b>2:30 PM</b> , from causes and on the date stated above                                      |   |   |  |
| 22a SIGNATURE<br><b>Bruce G. Bender</b>   |   | 22b DATE SIGNED<br><b>10-14-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS<br><b>Ar Geo Hospital Hospital</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>Oct 16, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D. C.</b>                         |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>  |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |  |
| ADDRESS<br><b>Hyattsville, Md.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><i>Montgomery</i><br>MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>b. COUNTY  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Bethesda</i>  |  | c. LENGTH OF STAY IN 1b<br><i>17 days</i>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Suburban Hospital</i>   |  | d. STREET ADDRESS<br><i>3503 PATTERSON ST NW</i>   |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><i>BERNARD</i>  |  | 4 DATE OF DEATH<br>Month <i>Oct</i> Day <i>20</i> Year <i>1967</i>   |   |
| 5 SEX<br><i>male</i>   | 6 COLOR OR RACE<br><i>white</i>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><i>11/28/91</i>  |
| 9 AGE (In years last birthday)<br><i>75</i> yrs  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Lawyer</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>  |   |
| 11 BIRTHPLACE (State or foreign country)<br><i>Johnstown Pa</i>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |   |
| 13 FATHER'S NAME<br><i>Bernard Garvey Sr.</i>  |  | 13 MOTHER'S MAIDEN NAME<br><i>Johanna Flinn</i>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>   |  | 16 SOCIAL SECURITY NO  |   |
| 17 INFORMANT<br><i>Address</i>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Intracranial hemorrhage, left cerebral hemisphere, massive</i><br><i>531X</i><br>DUE TO<br>(b) <i>due to cerebral arterio-sclerosis</i><br>DUE TO<br>(c) <i></i><br>(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>Fracture of Pelvis left - pelvic bone</i>  |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><i>Fall in nursing home causing fracture Pelvis</i>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br><i>10/3 1967</i>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.)<br><i>Nursing home</i>  | 20f. (City or town) (County) (State)<br><i>Bethesda Montgomery Md</i>           |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE<br><i>John B. Ball</i><br>EXAMINER'S NAME (Type)  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |   |
| 22. DATE SIGNED<br><i>Oct 20, 1967</i>   |  |  |   |
| 23a. BURIAL, CREMATION, or other disposition<br><i>BURIAL</i>  | 23b. DATE THEREOF<br><i>Oct. 23, 1967</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven</i>  | 23d. LOCATION (City or town) (County) (State)<br><i>Silver Spring Mont. Md.</i> |
| 24. FUNERAL DIRECTOR<br><i>Hanover Funeral Home</i><br>ADDRESS<br><i>4748 Wisc. Ave. NW</i>  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><i>OCT 30 1967</i>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                              |



## CERTIFICATE OF DEATH

1-1093

4088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |  |  |
|---|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |   | d. STREET ADDRESS <u>2713 Emmet Rd.</u>  |  |
| 3 NAME OF DECEASED (Type or print) <u>Hazel Grace Gates</u>   |   | 4. DATE OF DEATH <u>10-16</u> 19 <u>67</u>   |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-9-89</u>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>  |   | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13 FATHER'S NAME <u>William Koch</u>  |   | 14 MOTHER'S MAIDEN NAME <u>Ellen Murphy</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO <u>579 281294</u>   |  |
| 17. INFORMANT <u>Dr. Harry E. Bates</u>   |   | Address <u>Same as 2d</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO (b) <u>Coronary Artery Arteriosclerosis</u><br>DUE TO (c) <u>Chronic Arteriosclerosis</u>             |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>5 years</u><br><u>5 years</u>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. p.m. 19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                 |
| 21 I certify that (I) (this hospital) attended the deceased from <u>Jan 1965</u> to <u>Oct 16, 1967</u> , that (I) <u>did</u> last saw the deceased alive on <u>Oct 15, 1967</u> , and that death occurred at <u>11 AM</u> , from causes on and on the date stated above. |   |  |  |
| 22a. SIGNATURE <u>Michael R. O'Leary</u>  |   | 22b. DATE SIGNED <u>Oct 16, 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 23b. DATE THEREOF <u>10-19-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>  | 23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u> |
| 24. FUNERAL DIRECTOR <u>Lee Funeral Home 302 4th St. N.E.</u>   |   | 25a. REC'D BY REGISTRAR <u>Oct 18 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>O'Leary</u>   |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and fill with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pennington</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>District of Columbia</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Carroll Hall</u>   |   | d. STREET ADDRESS<br><u>609 33rd. St.</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Eli Zabe Th.</u>  |   | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>24</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10/13/85</u>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Germany</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Willhelm Bierenfeld</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Maria Dutterling</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |   | 16. SOCIAL SECURITY NO.<br><u>203-14-8638D</u>  |  |
| 17. INFORMANT<br><u>Mrs. Helen G. Troll (daughter)</u>  |   | Address <u>same item 12</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br><u>1810</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of lung with pneumonia</u><br>(c) <u>Cancer of bladder</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hrs.</u><br><u>6 months</u><br><u>5 yrs.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)         |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>10/24</u> , that (I) (we) last saw the deceased alive on <u>10/23</u> , <u>1967</u> , and that death occurred at <u>9</u> M, from the causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><u>[Signature]</u>  |   | 22b. DATE SIGNED<br><u>10/24/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>S.A. Thomas M.D.</u>   |   | 22d. ADDRESS<br><u>4301 48th St. NW Washington D.C.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City, town or county) (State) |
| <u>Burial-transit</u>   | <u>10/26/67</u>   | <u>Oak Hill Cemetery</u>  | <u>Clermont, Florida</u>                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Ty on Wheeler Funeral Home</u>   |   | 25a. REC'D BY REGISTRAR<br><u>OCT 26 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |   |  |



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14095

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>57 min</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Michigan</u> b. COUNTY <u>Benue</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flushing</u><br>d. STREET ADDRESS <u>5424 MAURA DRIVE</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>Eli</u> First <u>(son)</u> Middle <u>Goldin</u> Last<br>4. DATE OF DEATH <u>Oct</u> Month <u>12</u> Day <u>1967</u> Year  |  | 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Apr 30, 1874</u> 9. AGE (in years last birthday) <u>92-93</u> yrs   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Repairman</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Latvia, Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Sam Goldin</u> 14. MOTHER'S MAIDEN NAME <u>Riva</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u> 16. SOCIAL SECURITY NO. <u>365-34-5651A</u> 17. INFORMANT <u>ad. some one about Howard Goldin - son</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7201</u> DUE TO <u>Coronary Insufficiency Acute</u> (b) <u>Cardio-Vascular Disease</u> (c) <u>years</u>  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>   |  |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <u>John G. Ball</u> MD<br>EXAMINER'S NAME (Type) <u>JOHN G. BALL, MD.</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>10/12/67</u><br>Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMAINS <u>BURIAL</u>  |  | 23b. DATE THEREOF <u>10-13-67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Flint, Michigan</u>  |  | 23d. LOCATION (City or Town) (County) (State)   |  |
| 24. FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons</u> ADDRESS <u>Washington DC</u>  |  | 25a. RECD BY REGISTRAR <u>OCT 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1-10-66

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <b>Florida</b><br>b. COUNTY                                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>  |  | c. LENGTH OF STAY IN lb<br><b>12 days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>  |  | d. STREET ADDRESS<br><b>812 Hampton Way</b>   |  |
| e. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Eva</b> First <b>Y.</b> Middle <b>GOULDING</b> Last  |  | 4 DATE OF DEATH<br>Month <b>October</b> Day <b>5</b> Year <b>1967</b>   |  |
| 5 SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Cauc</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 23, 1910</b> |
| 9. AGE (In years last birthday)<br><b>57</b> yrs   |  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>19</b> Hours <b>11</b> Min <b>00</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Fort Kent, Maine</b>  |  | 12 CIT ZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Fabien Pinette</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Modeste Laferiere</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>Merritt Island</b> Address <b>Florida</b><br><b>Mr. Orin K. Goulding, 812 Hampton Way</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Congenital Heart Disease (Atrial Septal Defect)</b><br>DUE TO (b) <b>1070</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c) |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)     |
| 21. I certify that <b>19</b> (this hospital) attended the deceased from <b>Sept. 23</b> , 1967, to <b>Oct. 5</b> , 1967, that <b>19</b> (we) last saw the deceased alive on <b>Oct. 5</b> , 1967, and that death occurred at <b>200P</b> M, from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><b>Perry Ah-Tye</b>  |  | 22b. DATE SIGNED<br><b>Oct. 6, 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Perry Ah-Tye, MD</b>  |  | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>10-10-67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington, Virginia</b>   |  |
| 24 FUNERAL DIRECTOR <b>Lee Funeral Home</b> ADDRESS <b>D. C.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 11 1967</b>   |  |
| <b>4th and Massachusetts Ave., N.E. Washington, /</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



## CERTIFICATE OF DEATH

14097

|  |                              |   |   |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Dickerson</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>Dickerson</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>R.F.D. #2</u>   |                              | d. STREET ADDRESS<br><u>R.F.D. #2</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br><u>THOMAS</u> First Middle Last <u>GRAHAM</u>   |                              | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>28</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct. 9, 1887</u> |
| 9. AGE (in years last birthday) yrs<br><u>80</u>   |                              | 10. IF UNDER 1 YEAR<br>Months <u>28</u> Days <u>19</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>Maryland</u>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Tilghman Graham</u>  |                              | 14. MOTHER'S MAIDEN NAME<br><u>Winne Betters</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                              | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><u>Mrs. Mildred Graham</u>  |                              | Address <u>216 Rolling Ave E. Orange, N.J.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a</u><br>DUE TO (c) |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 months</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>advanced arteriosclerosis</u>   |                              | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15</u> , 1967, to <u>Oct 28</u> , 1967, that (I) (we) last saw the deceased alive on <u>27 Oct</u> 1967, and that death occurred at <u>6 P</u> M, from causes and on the date stated above.                            |                              |   |   |
| 22a. SIGNATURE<br><u>J. T. Lawrence</u> M.D.   |                              | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)   |                              | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                              | 23b. DATE THEREOF<br><u>Nov. 3, 1967</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Warren Chapel Cemetery</u>  |                              | 23d. LOCATION (City or Town) (County) (State)<br><u>Martinsburg, Montg. Md.</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>Robert L. Snowden</u>   |                              | 25a. REC'D BY REGISTRAR<br><u>Rockville, Md.</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>  |                              | DATE <u>NOV 6 1967</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





4093

## CERTIFICATE OF DEATH

14098

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CABIN JOHN</u>   |   | c. LENGTH OF STAY IN 1b<br><u>CABIN JOHN</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>6510 76th PLACE.</u>   |   | d. STREET ADDRESS<br><u>6510 76th PL.</u>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>LEWIS</u> Middle <u>A.</u> Last <u>GREGORY</u>   |   | 4. DATE OF DEATH<br>Month <u>OCT.</u> Day <u>20</u> Year <u>1967</u>  |   |
| 5 SEX <u>M.</u>   | 6 COLOR OR RACE <u>WHITE</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH<br><u>MAR 12, 1887</u>                                |
| 9 AGE (In years last birthday) <u>80</u> yrs  |   | IF UNDER 24 MRS<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>N. C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>   |   |
| 13. FATHER'S NAME<br><u>JOHN T. GREGORY</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>AMANDA</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>242-16-8881</u>   |   |
| 17. INFORMANT<br><u>MRS. SPATES (DAUGHTER)</u>  |   | Address<br><u>SAME</u>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia in Congestive Heart Failure</u><br>4000 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis &amp; paroplegia</u> DUE TO<br>(c) <u>5 yrs</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>63</u> , to <u>Oct</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/18</u> 19 <u>67</u> , and that death occurred at <u>10A</u> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><u>James J. Foster</u>  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                    | 22b. DATE SIGNED<br><u>10/20/67</u>                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Robert A. Doherty</u>  |   | 22d. ADDRESS<br><u>1746 K St. N.W.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE THEREOF<br><u>OCT 23, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>OUR LADY OF GARDEN NEWTON GROVE N.C.</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>WASHINGTON DC</u> |
| 24. FUNERAL DIRECTOR<br><u>Robert A. Doherty</u>  |   | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14099

|  |   |   |  |
|--|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Laytonsville</b> <span style="float: right;">50 Years</span><br>c. LENGTH OF STAY IN IB<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Rt. 2 Gaithersburg</b> |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Laytonsville</b><br>d. STREET ADDRESS<br><b>Rt. 2 Gaithersburg</b> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>LILLIAN NEEL GRIFFITH</b>   |   | <b>4. DATE OF DEATH</b> <b>Oct. 18 1967</b><br>a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| <b>5. SEX</b><br><b>Female</b>   | <b>6. COLOR OR RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><b>Sept. 5 1883</b> |
| <b>9. AGE</b> (In years last birthday) <b>84 yrs</b><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Montgomery Co. Md.</b>   |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>   |   | <b>13. FATHER'S NAME</b><br><b>James B. Neel</b>  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>Katharine Hoyle</b>  |   | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>   |  |
| <b>16. SOCIAL SECURITY NO.</b><br><b>Isabella G. Willett</b>   |   | <b>17. INFORMANT</b><br><b>Same as 2</b>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO (b) <b>Fluconema, bilateral</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>10 years, 5 years</b><br>DUE TO (c)                          |   |   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>10 years, 5 years</b>  |   |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that (I) (as a physician) attended the deceased from 8/15, 1946 to 10/18, 1967 that (I) saw the deceased alive on 10/14, 1967, and that death occurred at 7:25 AM from the causes and on the date stated above.</b>   |   |   |  |
| <b>22a. SIGNATURE</b><br><b>James P. Kerr</b> M.D.   |   | <b>22b. DATE SIGNED</b><br><b>10/18/67</b>  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>Damascus Md</b>  |   | <b>22d. ADDRESS</b><br><b>Damascus Md</b>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |   | <b>23b. DATE THEREOF</b><br><b>Oct. 20 1967</b>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Neelsville</b>   |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>Neelsville Montgomery co. Md.</b>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Francis H Barber</b>   |   | <b>25a. REC'D BY REGISTRAR</b><br><b>OCT 20 1967</b>  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>James H. Judge</b>   |   | <b>25c. REGISTRAR'S NAME</b><br><b>Md.</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

14100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br>---                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |   | c. LENGTH OF STAY IN 1b<br><b>4 Days</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center</b>  |   | d. STREET ADDRESS<br><b>1102 Trinity Drive</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>William (NMN) Grossman</b>   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>27</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>17 February 1915</b>                            |
| 9. AGE (in years lost birthday)<br><b>52 yrs.</b>   |   | IF UNDER 1 YEAR<br>Months <b>23</b> Days <b>1</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Insurance Agent</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>   |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>New York</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Samuel Grossman</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ida Maderman</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO<br><b>068-22-7346</b>  |  |
| 17. INFORMANT<br><b>The Medical Records Center, Bethesda, Maryland</b>  |   | 18. ADDRESS<br><b>The Clinical Center, Bethesda, Maryland 20014</b>   |  |
| 19. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pulmonary congestion and atelectasis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Macroglobulinemic Lymphoma</b><br>DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 Days</b><br><b>2 Years</b> |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (X) (this hospital) attended the deceased from <b>23 October 1967</b> , to <b>27 October 1967</b> , that (X) (we) last saw the deceased alive on <b>27 October 1967</b> , and that death occurred at <b>12:05 A.M.</b> from causes and on the date stated above  |   |   |  |
| 22a. SIGNATURE<br><i>Timothy G. Canty</i>   |   | 22b. DATE SIGNED<br><b>27 October 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Timothy G. Canty, MD.</b>  |   | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>  |  |
| 23a. BURIAL, CREMATION, REMOVA. (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10-29-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Agudas Achim Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Alexandria Va.</b> |
| 24. FUNERAL DIRECTOR<br><b>Goldberg Funeral Home, 4217 9th St., N.W.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 30 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Jones</i>                     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                                  |  |                                   | CERTIFICATE OF DEATH  |  | 1-1101   |  |
|--|----------------------------------|--|-----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                                  |  |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>WASHINGTON D.C.</u> b. COUNTY <u>✓</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CHEY CHASE</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>1 yr. 8 mos.</u>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>47-3</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>BETHESDA SILVER SPRING NURSING HOME</u>   |                                  |  |                                   | d. STREET ADDRESS<br><u>4740 Conn. Ave. N.W.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>ABRAHAM</u> Middle <u>HAFT</u> Last <u>HAFT</u>   |                                  |  |                                   | 4. DATE OF DEATH<br>Month <u>OCTOBER#</u> Day <u>26</u> Year <u>19 67</u>   |  |  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | B. DATE OF BIRTH<br><u>1/3/95</u> |   | 9. AGE (In years last birthday)<br><u>72</u> yrs | F. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>MERCHANT</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                                   | 11. BIRTHPLACE (County & State or foreign country)<br><u>RUSSIA</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>OSCAR HAFT</u>   |                                  |  |                                   | 14. MOTHER'S MAIDEN NAME<br><u>EVA HOFFMAN</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>577-34-6923</u>  |                                   | 17. INFORMANT<br><u>ABRAHAM HAFT</u>  |  | Address <u>4540 Conn. Ave. N.W. WASHINGTON, D.C.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO <u>4 hours</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u><br>DUE TO <u>more than 5 years</u><br>(c) |                                  |  |                                   | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |  |                                   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19 _____  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 6, 1966</u> , to <u>Oct 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 26, 1967</u> , and that death occurred at <u>3 P.M.</u> from causes and on the date stated above.  |                                  |  |                                   |   |  |  |  |
| 22a. SIGNATURE<br><u>Warren D. Brill</u>   |                                  |  |                                   | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>          |  | 22b. DATE SIGNED<br><u>10/26/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>WARREN D. BRILL, M. D.</u>  |                                  |  |                                   | 22d. ADDRESS<br><u>2601 16th St. N. W. Washington, D. C.</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 23b. DATE THEREOF<br><u>10-29-67</u>   |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>KING DAVID MEMORIAL GARDEN FALLS CHURCH - VA</u>   |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| 24. FUNERAL DIRECTOR<br><u>B. Danzansky + Sons</u>   |                                  |  |                                   | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 30 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |

Wash. D.C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14102

|   |                           |   |                                 |  |                                      |   |  |
|---|---------------------------|---|---------------------------------|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |                           | MARYLAND  |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br>New Jersey |                                      | b. COUNTY   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda  |                           | c. LENGTH OF STAY IN 1b<br>15 Days  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Nutley                     |                                      |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>The Clinical Center, Bethesda, Maryland   |                           |   |                                 | d. STREET ADDRESS<br>25 Highfield Lane   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Kevin Joseph Haines   |                           | First Middle Last   |                                 | 4. DATE OF DEATH<br>October 13 1967  |                                      | Month Day Year  |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br>9 June 1961 |  | 9. AGE (In years last birthday)<br>6 | If UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br>Student   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  |                                 | 11. BIRTHPLACE (County & State, or foreign country)<br>New Jersey  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Robert F. Haines   |                           |   |                                 | 14. MOTHER'S MAIDEN NAME<br>Ann Claire Longworth   |                                      |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No  |                           | 16. SOCIAL SECURITY NO<br>None  |                                 | 17. INFORMANT<br>The Medical Records, The Clinical Center, Bethesda, Maryland 20014                            |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory collapse</u><br>DUE TO<br>(b) <u>Brain involvement with lymphoma</u><br>DUE TO<br>(c) <u>Poorly differentiated lymphosarcoma</u> |                           |   |                                 |  |                                      | INTERVAL BETWEEN ONSET AND DEATH<br>10 minutes<br>6 weeks<br>3 months                             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |   |                                 |  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |                                 |  |                                      |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |                           | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)  |                                      | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (X) (this hospital) attended the deceased from 28 September 1967, to 13 October 1967, that (X) (we) lost saw the deceased alive on 13 October 1967, and that death occurred at 6:55M, from causes and on the date stated above.                                    |                           |   |                                 |  |                                      |   |  |
| 22a. SIGNATURE<br><i>Charles M. Haskell, MD</i>   |                           | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> A.M. STAFF PHYS. <input checked="" type="checkbox"/>                   |                                 | 22b. DATE SIGNED<br>13 October 1967  |                                      |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>Charles M. Haskell, MD  |                           | 22d. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014   |                                 |  |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 23b. DATE THEREOF<br>10-16-67   |                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Mary Rose Cemetery, Berlin, N.J.   |                                      | 23d. LOCATION (City or Town) (County) (State)<br>N.J.   |  |
| 24. FUNERAL DIRECTOR<br>ROBERT A. PUMPHREY, Bethesda, Maryland  |                           | 25a. REC'D BY REGISTRAR<br>DATE OCT 18 1967   |                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |                                      |   |  |



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



99

| <div>14598</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14103</div>  |  |                                 |   |   |   |   |  |   |   |
|---|--|---------------------------------|---|---|---|---|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND   |  |                                 |   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY <b>Anne Arundel</b> |   |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |                                 | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Edgewater</b>  |   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Suburban</b>   |  |                                 |   |   | d. STREET ADDRESS<br><b>Rt #1, Box 208</b>  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED (Type or print)<br><b>Francis</b> First <b>X</b> Middle <b>Harlow</b> Last   |  |                                 |   |   | 4 DATE OF DEATH<br>Month <b>October</b> Day <b>17</b> Year <b>1967</b>  |   |  |   |   |
| 5 SEX<br><b>Male</b>  |  | 6 COLOR OR RACE<br><b>White</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>5/13/1939</b>          |  | 9. AGE (In years last birthday) yrs <b>28</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Elec. Mechanic</b>  |  |                                 |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Power Co.</b>   |   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Canada</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S</b>  |  |                                 |   |   |   |   |  |   |   |
| 13. FATHER'S NAME<br><b>Wm McShath Harlow</b>   |  |                                 |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Simmons</b>   |   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>U.S. Coast Guard Res.</b>   |  |                                 | 16. SOCIAL SECURITY NO  |   | 17. INFORMANT<br><b>EVA H HARLOW</b>  |   |  | Address <b>#2</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Electrocution -</b><br><b>9143</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____  |  |                                 |   |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MIN</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)   |  |                                 |   |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Touched a live wire that should have been dead.</b>                              |   |   |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>8:00</b> <b>Oct 17 1967</b>  |  |                                 | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/><br>at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Power Station</b>  |   | 20f. (City or town) (County) (State)<br><b>R Gaithersburg - Mont. Md.</b>    |   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                 |   |   |   |   |  |   |   |
| ACTUAL SIGNATURE<br><b>John S. Ball</b>   |  |                                 | EXAMINER'S NAME (Type)<br><b>JOHN S. BALL</b>   |   |   | 22. DATE SIGNED<br><b>Oct. 17, 1967</b>       |  |   | 22. DATE SIGNED   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                                 | 23b. DATE THEREOF<br><b>10-20-67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEM.</b>  |   | 23d. LOCATION (City or town) (County) (State)<br><b>PRINCE GEORGE CO. MD</b> |   |   |
| 24. FUNERAL DIRECTOR<br><b>John M. Taylor</b>   |  |                                 | ADDRESS<br><b>San Annapolis, Md</b>   |   |   | 25a. REC'D BY REGISTRAR<br><b>Oct 19 1967</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |



4099

## CERTIFICATE OF DEATH

14104

Reg. Dist. No.

|  |                                  |  |   |   |   |
|--|----------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chevy Chase</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>30 Years</u>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chevy Chase</u>  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>7209 Chestnut Street</u>  |                                  |  | d. STREET ADDRESS<br><u>7209 Chestnut Street</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>FRANK HASTINGS HARRISON</u>  |                                  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>October 9, 19 67</u>   |   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>Sept. 7, 1892</u>  |   | 9. AGE (In years last birthday)<br><u>75</u> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Real Estate</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>London, England</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>  |
| 13. FATHER'S NAME<br><u>John Harrison</u>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><u>Phoebe Keg</u>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>578-09-2514</u>  | 17. INFORMANT<br><u>Wife</u> Address <u>Same as Item 2.</u><br><u>Harriet B. Harrison</u>   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cholangiocarcinoma, multiple of liver</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____<br>DUE TO (c) _____ |                                  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 months</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                  |  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. _____ 19 _____   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____                      |   |
|  |                                  | 20f. (City or town) _____ (County) _____ (State) _____   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21. I certify that I attended the deceased from <u>1942</u> to <u>Oct 9</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>67</u> , and that death occurred at <u>6<sup>44</sup></u> A.M. from the causes and on the date stated above.   |                                  |  |   |   |   |
| ACTUAL SIGNATURE <u>Stewart Clapp</u>  |                                  | ADDRESS (Street, city or town, state) <u>4740 Chevy Chase Dr. Oct 9, 1967</u>  |   |   |   |
| PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>  |                                  | DATE SIGNED <u>Oct 9, 1967</u>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>10-12-67</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>                                    |   |
|  |                                  |  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Rockville, Maryland</u>                       |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>ROBERT L. PUMPHREY</u>  |                                  |  | ADDRESS<br><u>Bethesda, Maryland</u>  |   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 16 1967</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles J. ...</u>  |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14105

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Echo</b>   |                                  | c. LENGTH OF STAY IN TB<br><b>20 years</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>48 Wellesley Circle</b>   |                                  | e. STREET ADDRESS<br><b>48 Wellesley Circle</b>   |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>HOWARD W. HARRISON</b>  |                                  | 4 DATE OF DEATH<br>Month <b>Oct.</b> Day <b>31</b> , Year <b>67</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 1, 1907</b> |
| 9. AGE (In years last birthday)<br><b>60</b> yrs   |                                  | 10. IF UNDER 1 YEAR: Months <b>19</b> Days <b>67</b> Hours <b>19</b> Min <b>67</b>  |   |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Warehouseman</b>  |                                  | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing Sup.</b>   |   |
| 12. BIRTHPLACE (County & State, or foreign country)<br><b>Oklahoma</b>   |                                  | 13. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |   |
| 14. FATHER'S NAME<br><b>William Henderson Harrison</b>   |                                  | 15. MOTHER'S MAIDEN NAME<br><b>Josephine Elizabeth Mark</b>   |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of serv.)<br><b>No</b>  |                                  | 17. SOCIAL SECURITY NO<br><b>577-07-0884</b>  |   |
| 18. INFORMANT<br><b>Wife</b>   |                                  | 19. ADDRESS<br><b>Same as Item 2.</b>   |   |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b><br>DUE TO (b) <b>Hypoxemia</b><br>DUE TO (c) <b>Emphysema</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>18 mos</b><br><b>5 years</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April, 1966</b> , to <b>October, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct. 26, 1967</b> , and that death occurred at <b>7:30 PM</b> , from causes and on the date stated above. |                                  |   |   |
| 22a. SIGNATURE<br><b>R.W. Langewies</b>  |                                  | 22b. DATE SIGNED<br><b>Oct 31 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>R.W. Langewies, MD</b>  |                                  | 22d. ADDRESS<br><b>1234 19th St. N.W. Wash. DC.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>11-2-67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Prince George County, Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>NOV 2 1967</b>  |   |
|  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |





14101

## CERTIFICATE OF DEATH

14106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓<br>a. STATE <u>West Virginia</u> b. COUNTY _____ |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |   | c. LENGTH OF STAY IN 1b<br><u>5 days</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pettus</u>                                       |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>   |   |   | d. STREET ADDRESS<br><u>(None)</u>  |  | e. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |
| 3. NAME OF DECEASED (Type or print)<br>First <u>James</u> Middle <u>Richard</u> Last <u>Hash</u>   |   |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>28</u> Year <u>1967</u>   |  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><u>Jan. 22, 1965</u>  |  | 9. AGE (In years last birthday)<br><u>2</u> yrs   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><u>Child</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>West Virginia</u>   |  | 12. C. 1. TEN OF WHAT COUNTRY?<br><u>USA</u>  |
| 13. FATHER'S NAME<br><u>James A. Hash</u>  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Phyllis Payne</u>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>None</u>   | 17. INFORMANT <u>The Medical Record</u> Address<br><u>The Clinical Center, Bethesda, Maryland</u>                                       |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Pseudomonas septicemia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Wiskott-Aldrich syndrome</u><br>DUE TO<br>(c) _____   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u><br><u>2 1/2 years</u>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> o.m. p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town)   | (County)   | (State)   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 23, 1967</u> to <u>Oct. 28, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 28, 1967</u> , and that death occurred at <u>9:12 M.</u> from causes and on the date stated above. |   |   |   |  |   |
| 22a. SIGNATURE<br><u>Charles M. Haskell</u>  |   |   | M.D. ATTENDING PHYS <input type="checkbox"/> A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | 22b. DATE SIGNED<br><u>Oct. 28, 1967</u>           |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Charles M. Haskell, M.D.</u>  |   |   | 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><u>10-30-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or town)  | (County)   | (State)   |
| 24. FUNERAL DIRECTOR<br><u>Frozen 389 B.I. see new work</u>  |   | ADDRESS   | 25a. REC'D BY REGISTRAR<br><u>OCT 31 1967</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14102

CERTIFICATE OF DEATH

1-1107

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>o. STATE<br><b>MARYLAND</b> b. COUNTY<br><b>MONTGOMERY</b>          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma PARK</b>   |  | c. LENGTH OF STAY IN 1b<br><b>16 hours</b>   |  | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Takoma PARK</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>  |  |  |  | d. STREET ADDRESS<br><b>7327 CARROLL AVE</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>RHEE DOROTHEA HAUGHN</b><br>First Middle Last  |  |  |  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>17</b> Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/31/21</b>  |  |
| 9. AGE (In years lost birthday)<br><b>46</b> yrs   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Legal Secretary</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>CANADA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>CREIGHTON HAUGHN</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>MILDRED CONRAD</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/><br><b>UNKNOWN</b>   |  | 16. SOCIAL SECURITY NO.<br><b>015-14-7520</b>  |  | 17. INFORMANT<br><b>Charles Haughn, Jr.</b> Address<br><b>7327 Carroll Ave. Takoma Park, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hem. Masses</b><br>DUE TO (b) <b>Coronary Thrombosis</b><br>DUE TO (c) <b>28 hrs.</b>                                    |  |  |  |   |  | INTERVAL BETWEEN DEATH AND DEATH  |  |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (1) (this hospital) attended the deceased from <b>8/21/67</b> , 1967, to <b>10/17/67</b> , that (1) (we) last saw the deceased alive on <b>10/16/67</b> , and that death occurred at <b>10/17/67</b> M, from causes and on the date stated above. |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Howard T. Morse</b>   |  |  |  | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                           |  | 22b. DATE SIGNED<br><b>10/17/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Howard T. Morse</b>   |  |  |  | 22d. ADDRESS<br><b>7030 Carroll Avenue, Takoma Park, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>Oct. 20, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Providence Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rockville, Maryland</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>John B. Hays</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 23 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

14103

CERTIFICATE OF DEATH

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md.</u> 20910 b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TAKOMA PARK</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>WASHINGTON SAN &amp; HOSPITAL</u>  |  | d. STREET ADDRESS<br><u>8540 2nd Ave #3</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Celia</u> Middle <u>(None)</u> Last <u>Havice</u>   |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>28</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>FE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6-12-76</u>  |
| 9. AGE (In years lost birthday) yrs.<br><u>91</u>   |  | IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>28</u> Hours <u>19</u> Min <u>67</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>retired</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Penn.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>JAMES BOONE</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Amanda Love</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO<br><u>192-10-6376</u>  |   |
| 17. INFORMANT<br><u>Hospital Records</u>  |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>many years</u>   |  |   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)<br><u>Fracture Left Hip</u>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>not known</u>  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>Fall at Home 3 weeks prior to death</u>                    |   |
| 20c. TIME OF INJURY Month, Day, Year<br><u>not known</u> 19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>   | 20f. (City or town) (County) (State)<br><u>Silver Spring, Montg. Md.</u>    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-9-</u> 19 <u>67</u> to <u>10-28-</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-27-</u> 19 <u>67</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><u>Jay A. McRobert</u>  |  | 22b. DATE SIGNED<br><u>10-28-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JAY A. McROBERTS</u>   |  | 22d. ADDRESS<br><u>1400 Spring Street Silver Spring, Md.</u>  |   |
| 23a. BURIAL, CREMATION, MORTUARY (State)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>10/29/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Coulterville Cem.</u>  | 23d. LOCATION (City or town) (County) (State)<br><u>Westmorland Co. Pa.</u> |
| 24. FUNERAL DIRECTOR<br><u>Robert A. Pumphrey Bethesda, Md.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>NOV 1 1967</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. [Signature]</u>   |  |   |   |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

14104

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14109

|   |                           |  |                                  |
|---|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>                                  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>  |                                  |
| c. LENGTH OF STAY in 1b <u>7 1/2 hrs</u>  |                           | d. STREET ADDRESS <u>7002 Highview Terrace</u>   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>James Albert Heath</u>   |                           | 4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1967</u>  |                                  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                           | 8. DATE OF BIRTH <u>12-23-46</u> |
| 9. AGE (In years lost birthday) yrs <u>20</u>   |                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>  |                                  |
| 11. BIRTHPLACE (State or foreign country) <u>Penna.</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                  |
| 13. FATHER'S NAME <u>James Heath</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Mary Isabelle Shapiro</u>  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |                           | 16. SOCIAL SECURITY NO <u>Unknown</u>  |                                  |
| 17. INFORMANT <u>HOSP. Record</u>   |                           | Address  |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized, severe, subarachnoid and</u><br>DUE TO (b) <u>intracranial hemorrhage due to</u><br>stating the underlying cause lost. (c) <u>auto accident.</u>  |                           |  |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>816.4</u>  |                           |  |                                  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |  |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Deceased was a passenger in auto when driver lost control colliding with a car.</u> |                                  |
| 20c. TIME OF INJURY Month, Day, Year <u>11:50 PM 10/18/1967</u>   |                           | 20d. PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.) <u>Street</u>   |                                  |
| 20e. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work   |                           | 20f. (City or town) (County) (State) <u>Adelphi Fr. Geo. Md.</u>   |                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |                                  |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.   |                           | 22. DATE SIGNED <u>10/19/1967</u>  |                                  |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                    |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>  |                           | 23b. DATE THEREOF <u>Oct 20, 1967</u>  |                                  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>  |                           | 23d. LOCATION (City or town) (County) (State) <u>Bladensburg Md.</u>   |                                  |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers Co 8655 Ga Ave Silver Spring Md</u>   |                           | 25a. REC'D BY REGISTRAR <u>W.W. Chambers</u>   |                                  |
| ADDRESS   |                           | 25b. REGISTRAR'S SIGNATURE <u>W.W. Chambers</u>  |                                  |
| DATE <u>OCT 23 1967</u>   |                           | 25c. REGISTRAR'S SIGNATURE <u>W.W. Chambers</u>  |                                  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14103

14110

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>7</u>                |   |
| c. LENGTH OF STAY IN 1b <u>8 days 2 1/2 hrs</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>#yattsville</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>  |  | d. STREET ADDRESS <u>8135 15th Ave. Apt. 203</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Ethel</u> First <u>Maud</u> Middle <u>Higgins</u> Last  |  | 4. DATE OF DEATH <u>October 2</u> Month <u>19</u> Day <u>67</u> Year   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 19, 1892</u> 77 yrs                     |
| 9. AGE (In years last birthday) <u>77</u> yrs   |  | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>  | 11. IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.N. retired</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State or foreign country) <u>England</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>William Head</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Thirza Biddlescomb</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |  | 16. SOCIAL SECURITY NO <u>376-30-9944</u>  |   |
| 17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave.</u>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>URemia</u><br><u>171X</u> DUE TO<br>Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Metastatic CA of Cervix</u> DUE TO<br>(c) |  |  |   |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-23-67</u> , 19 <u>67</u> , to <u>10-2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-1</u> , 19 <u>67</u> and that death occurred at <u>2:15</u> A.M. from causes and on the date stated above                            |  |  |   |
| 22a. SIGNATURE <u>83 Cushner</u>  |  | 22b. DATE SIGNED <u>10-2-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>11161 New Hampshire Ave.</u>  |  | 22d. ADDRESS   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>  | 23b. DATE THEREOF <u>2 Oct. 67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Washington, DC</u> |
| 24. FUNERAL DIRECTOR <u>Rinaldi Funeral Home</u> ADDRESS <u>DC 20012</u>  |  | 25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                     |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, staples, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14106

CERTIFICATE OF DEATH

14111

|   |                              |  |                                    |
|---|------------------------------|--|------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                              | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Texas</u> b. COUNTY                                     |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TAKOMA PARK</u>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bloomburg</u>   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington San &amp; Hospital.</u>   |                              | d. STREET ADDRESS<br><u>Route 41</u>   |                                    |
| 3. NAME OF DECEASED<br>(Type or print) <u>Clara Randolph Hill</u>   |                              | 4. DATE OF DEATH<br>Month <u>10</u> - Day <u>16</u> - Year <u>1967</u>   |                                    |
| 5 SEX<br><u>Fe</u>  | 6. COLOR OR RACE<br><u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>5-18-97</u> |
| 9. AGE (In years, last birthday)<br><u>70</u> yrs   |                              | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u>  |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Georgia</u>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |                                    |
| 13. FATHER'S NAME<br><u>William Howard</u>  |                              | 14. MOTHER'S MAIDEN NAME<br><u>Florence Moore</u>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)  |                              | 16. SOCIAL SECURITY NO<br><u>346-16-7892</u>   |                                    |
| 17. INFORMANT<br><u>no</u>  |                              | Address  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO <u>INCREASING INTRACRANIAL PRESS 2 months</u><br>(b) <u>ASTROCYTOMA</u><br>DUE TO <u>PRIMARY BRAIN TUMOR (GRADE II) 3-4 months</u><br>(c) <u>MINIMAL</u> |                              |  |                                    |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Minimal</u>  |                              |  |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | INTERVAL BETWEEN ONSET AND DEATH   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                    |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. 19 p.m.  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-31</u> , 1967, to <u>10-16</u> , 1967, that (I) (we) last saw the deceased alive on <u>10-16</u> , 1967, and that death occurred at <u>7:50 PM</u> , from causes and on the date stated above.   |                              |  |                                    |
| 22a. SIGNATURE<br><u>John L Ford</u>  |                              | 22b. DATE SIGNED<br><u>10-17-67</u>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOHN LOUIS FORD, MD</u>  |                              | 22d. ADDRESS<br><u>831 UNIVERSITY BLVD E. SILVER SPRING, MD</u>  |                                    |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><u>BURIAL</u>   |                              | 23b. DATE THEREOF<br><u>10/19/67</u>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Wood Cemetery</u>  |                              | 23d. LOCATION (City or Town) (County) (State)<br><u>Mt. Vernon, Illinois</u>   |                                    |
| 24. FUNERAL DIRECTOR<br><u>Francis Gasch's Sons</u>   |                              | 25a. REC'D BY REGISTRAR<br><u>Charles Young</u>  |                                    |
| ADDRESS<br><u>4739 Baltimore Ave Hyattsville, Md. 20781</u>   |                              | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Young</u>   |                                    |



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1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14107

CERTIFICATE OF DEATH

14112

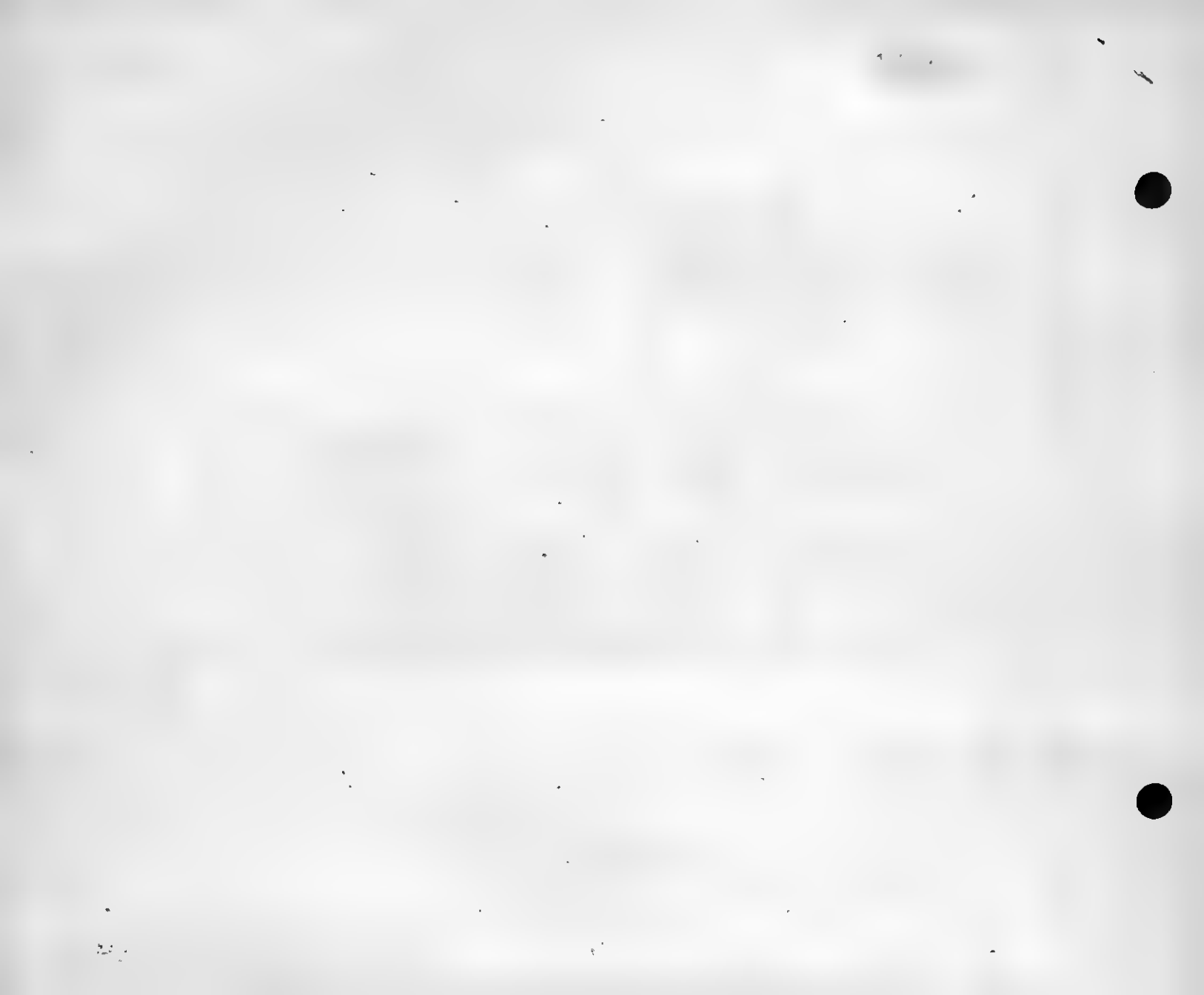
|  |                                 |   |                                     |   |  |   |  |
|--|---------------------------------|---|-------------------------------------|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                 |   |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY           |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u>   |                                 | c. LENGTH OF STAY IN 1b<br><u>1 1/2 mos.</u>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u>                             |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>University Nursing Home</u>   |                                 |   |                                     | d. STREET ADDRESS<br><u>1401 A Buchanan Street, N.W.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <u>Susanna</u> Middle <u>nmn</u> Last <u>Howell-Hill</u>  |                                 |   |                                     | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>14</u> Year <u>1967</u>  |  |   |  |
| 5 SEX<br><u>Female</u>   | 6 COLOR OR RACE<br><u>Caus.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>7/22/1882</u> | 9 AGE (In years lost birthday)<br><u>85</u> yrs   | 10 IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>14</u> Hours <u>19</u> Min. |   |  |
| 10a. USUA. OCC. PAT. ON (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |                                     | 11. BIRTHPLACE (County & State or foreign country)<br><u>Jefferson County, W. Va.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13 FATHER'S NAME<br><u>Joseph Robert Howell</u>  |                                 |   |                                     | 14 MOTHER'S MAIDEN NAME<br><u>Jeanne Susan Miller</u>   |  |   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                 | 16. SOCIAL SECURITY NO.<br><u>578-48-5734</u>   |                                     | 17 INFORMANT<br><u>Edna O. Waugh-daugh. 7309 Wildwood Dr.</u>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>332X DUE TO <u>Probable Basilar Artery Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2° Arteriosclerotic Disease</u><br>DUE TO (c) |                                 |   |                                     |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                 |   |                                     |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 |   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>Death occurred Oct. 14, 1967</u> |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work  |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1967</u> to <u>Oct. 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 13, 1967</u> , and that death occurred at <u>9:15 P.M.</u> from causes and on the date stated above.  |                                 |   |                                     |   |  |   |  |
| 22a. SIGNATURE<br><u>R.C. Bufalino</u>   |                                 |   |                                     | 22b. DATE SIGNED<br><u>Oct. 14, 1967</u>  |  | 22c. PHYSICIAN'S NAME (Type)<br><u>R.C. BUFALINO</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                 | 23b. DATE THEREOF<br><u>10-18-1967</u>  |                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Cem.</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Colmar Manor, Maryland</u>                    |  |
| 24. FUNERAL DIRECTOR<br><u>Lee Fun. Home 300 4th St. NE, Wash., D.C.</u>   |                                 |   |                                     | 25a. REC'D BY REGISTRAR<br><u>DATE OCT 17 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>William J. Judge</u>   |  |



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| <div>14108</div> <div>14113</div>  |  |                            |  |  |  |   |  |  |  |  |  |
|--|--|----------------------------|--|--|--|---|--|--|--|--|--|
| <div>1</div> <div>1</div>  |  |                            |  |  |  |   |  |  |  |  |  |
| <div>1</div> <div>1</div>  |  |                            |  |  |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4421 Brooklyn Lane</u>   |  |                            |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u><br>d. STREET ADDRESS <u>4421 Brooklyn Lane</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Gertrude Fay Hoage</u>  |  |                            |  |  |  | 4. DATE OF DEATH <u>Oct 13 1967</u>   |  |  |  |  |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W.</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>10/8/87</u>   |  | 9. AGE (In years last birthday) <u>80</u> yrs.                       |  | IF UNDER 1 YEAR Months Days Hours Min.                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |                            |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |   |  | 11. BIRTH PLACE (County & State, or foreign country) <u>WASH DC.</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>                       |  |
| 13. FATHER'S NAME <u>WALTER BROWN</u>  |  |                            |  |  |  | 14. MOTHER'S MAIDEN NAME <u>MARY ELIZ. B. FORD</u>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |                            |  | 16. SOCIAL SECURITY NO. <u>217-44-6411</u>   |  | 17. INFORMANT <u>Allen W Hoage</u>  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u><br>DUE TO <u>Coronary Artery Disease</u><br>DUE TO <u>Generalized Arteriosclerosis</u><br>(c) <u>Hypertension</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                            |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u><br><u>15 yrs</u> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                            |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  |                            |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                 |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 26 1954</u> to <u>Oct 13 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 4 1967</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.  |  |                            |  |  |  |   |  |  |  |  |  |
| 22a. SIGNATURE <u>E. Herbert Bauersfeld</u>  |  |                            |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED <u>10/13/67</u>                                     |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>E. Herbert Bauersfeld</u>  |  |                            |  |  |  | 22d. ADDRESS <u>2401 Calvert St. N.W.</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF          |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City, town or county) (State)  |  |  |  |  |  |
| <u>Urinal</u>  |  | <u>10-16-67</u>            |  | <u>Glenwood Cemetery</u>   |  | <u>Washington, D. C.</u>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |  |                            |  |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                      |  |  |  |
|  |  |                            |  |  |  | DATE <u>OCT 18 1967</u>   |  |  |  |  |  |





FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 12-21 Film 303  
10-23-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14114

|  |                                 |   |                                  |
|--|---------------------------------|---|----------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>   |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b> |                                  |
| c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>   |                                 | d. STREET ADDRESS<br><b>1014 EAST-WEST HIGHWAY</b>  |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>  |                                 | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>CARROLL ARCHIE HODGES</b>   |                                 | 4 DATE OF DEATH<br>Month Day Year<br><b>10 - 10 19 67</b>   |                                  |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>WHITE</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>6-4-17</b> |
| 9 AGE (in years last birthday)<br><b>50</b> yrs  |                                 | 10 IF UNDER 1 YEAR<br>Months Days   | 11 F UNDER 24 HRS<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MAIL CARRIER</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt</b>   |                                  |
| 11 BIRTHPLACE (State or foreign country)<br><b>NORFOLK, VIRGINIA</b>   |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  |
| 13 FATHER'S NAME<br><b>JOHN HODGES</b>   |                                 | 14 MOTHER'S MAIDEN NAME<br><b>ADELIA WHITEHURST</b>   |                                  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES</b>  |                                 | 16 SOC. SEC. NO.<br><b>579-32-9009</b>  |                                  |
| 17 INFORMANT<br><b>Mrs. Mary E. Hodges</b>   |                                 | Address<br><b>1014 East West Highway<br/>Takoma Park, Md</b>  |                                  |
| 18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>acute coronary insufficiency and</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>Congestive heart failure due to</b><br>DUE TO<br>(c) <b>Arteriosclerotic heart disease</b>   |                                 |   |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>INTERVAL BETWEEN ONSET AND DEATH</b>   |                                 |   |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)  |                                  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |   |                                  |
| 22. DATE SIGNED<br><b>Oct. 10, 1967</b>  |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MED. CA. EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (If not cert. bldg. or county)  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>10/14/67</b>   |                                 | 23b. DATE THEREOF<br><b>10/14/67</b>  |                                  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>mt. Olivet Cem</b>  |                                 | 23d. LOCATION (City or town) (County) (State)<br><b>Wash DC</b>   |                                  |
| 24. FUNERAL DIRECTOR<br><b>H. J. Hutterman</b>   |                                 | 25a. REC'D BY REGISTRAR<br><b>5792 Wa</b>   |                                  |
| 25b. REGISTRAR'S SIGNATURE<br><b>SEN Funeral Home</b>  |                                 | 25c. DATE<br><b>OCT 16 1967</b>   |                                  |



14110

## CERTIFICATE OF DEATH

14115

|   |                           |   |                                 |  |                                       |  |  |
|---|---------------------------|---|---------------------------------|--|---------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |                           |   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |                                       |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRINGS</b>   |                           |   |                                 | c. LENGTH OF STAY IN TB  |                                       |  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WHEATON, MD.</b>   |                           |   |                                 | d. STREET ADDRESS<br><b>1722 FRANWALL AVE.</b>   |                                       |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>HOLY CROSS HOSPITAL</b>  |                           |   |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |  |  |
| 3. NAME OF DECEASED (Type or print) <b>GEORGE</b> First <b>HOLTZAPPEL</b> Middle Last   |                           |   |                                 | 4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>1967</b>   |                                       |  |  |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>5/18/89</b> | 9. AGE (In years last birthday) <b>78</b> yrs  | IF UNDER 1 YEAR Months Days Hours Min |  | IF UNDER 24 HRS  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>  |                                 | 11. BIRTHPLACE (County & State, or foreign country)<br><b>York County Pa</b>   |                                       | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>George A Holtzapfel</b>   |                           |   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Pieter</b>   |                                       |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                           | 16. SOCIAL SECURITY NO<br><b>197-03-3892</b>  |                                 | 17. INFORMANT Address<br><b>Ethel Newsom 1722 Franwall Ave Wheaton Md</b>  |                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                           |   |                                 |  |                                       |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                           |   |                                 |  |                                       |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                 |  |                                       |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                       | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 1959, to <b>10-12</b> 1967 that (I) (we) last saw the deceased alive on <b>10-12</b> 1967, and that death occurred at <b>11:30</b> P.M. from causes and on the date stated above.  |                           |   |                                 |  |                                       |  |  |
| 22a. SIGNATURE<br><b>Golden R. Reap</b>   |                           |   |                                 | 22b. DATE SIGNED<br><b>10-13-1967</b>  |                                       | 22c. PHYSICIAN'S NAME (Type)<br><b>BELDEN R. REAP, M.D.</b>                    |  |
| 22d. ADDRESS<br><b>Wheaton, Maryland</b>  |                           |   |                                 |  |                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                           | 23b. DATE THEREOF<br><b>Oct 16 1967</b>   |                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lewisburg Cemetery</b>  |                                       | 23d. LOCATION (City or town) (County) (State)<br><b>Lewisburg Pennsylvania</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Warner &amp; Pumphrey, Inc 8434 Ga Ave S.L. Spa Md</b>   |                           |   |                                 | 25a. REC'D BY REGISTRAR<br><b>OCT 20 1967</b>  |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                             |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14111

CERTIFICATE OF DEATH

14116

|   |                                  |   |                                      |   |   |  |  |
|---|----------------------------------|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission)<br>a. STATE <u>DELAWARE</u> b. COUNTY <u>Kent</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>3 yrs 8 mo.</u>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FREDERICA</u>                                  |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>FAIRLAND NURSING HOME 2101 FAIRLAND</u>  |                                  |   |                                      | d. STREET ADDRESS   |   | e. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>Lillian A Hopkins</u>   |                                  |   |                                      | 4. DATE OF DEATH<br>Month Day Year<br><u>October 13 1967</u>  |   |  |  |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7/18/1887</u> |   | 9. AGE (in years lost birthday)<br><u>80</u> yrs. | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (County & State or foreign country)<br><u>Kent Co. Delaware</u>  |   | 12. C. TIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>THOMAS ALEXANDER</u>  |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>MARY QUILLEN</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br><u>222-22-6465-A</u>   |                                      | 17. INFORMANT<br><u>Homer Hopkins, 4500 Elmwood Rd. Beltsville, Md.</u>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Ch Myocardial</u><br>47.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____                 |                                  |   |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                      |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |                                      |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28</u> , 19 <u>67</u> to <u>Oct 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 13</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above. |                                  |   |                                      |   |   |  |  |
| 22a. SIGNATURE<br><u>Robert S. McCeney, M.D.</u><br>ROBERT S. MCCENEY, M.D.<br>402 MAIN ST.<br>LAUREL, MARYLAND 20810   |                                  |   |                                      | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |   | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type)  |                                  | 22d. ADDRESS  |                                      |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>10/16/67</u>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Barratts Chapel</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>FredERICA, Kent, Del.</u>                  |  |
| 24. FUNERAL DIRECTOR<br><u>Charles Judge</u>  |                                  |   |                                      | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |
| DATE <u>OCT 18 1967</u>   |                                  |   |                                      |   |   |  |  |









CERTIFICATE OF DEATH

14118

14118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN TB <u>1 hr. 35 min</u>  |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Pand Md</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u><br>d. STREET ADDRESS <u>166175 Westland Dr</u> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>James C Hurley</u><br>First Middle Last<br>4. DATE OF DEATH <u>Oct 27 1967</u><br>Month Day Year   |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>8/30/84</u><br>9. AGE (In years last birthday) <u>83</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Employee</u>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   | 11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>                  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>  |                                   | 13. FATHER'S NAME <u>Henry Hurley</u>  |  |
| 14. MOTHER'S MAIDEN NAME <u>Laura Cline</u>  |                                   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |  |
| 16. SOCIAL SECURITY NO <u>287-10-3342A</u>   |                                   | 17. INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u><br><u>Ida C. Hurley</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u><br>DUE TO (b) <u>411X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Indirect inguinal hernia with incarcerated early moist gangrene.</u> |                                   |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Indirect inguinal hernia with incarcerated early moist gangrene.</u>  |                                   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                   | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |                                   | 20c. TIME OF INJURY Month, Day, Year<br>Hour o m p m. <u>19</u>  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)  |  |
| 20f. (City or town) (County) (State)   |                                   | 21. I certify that (I) (this hospital) attended the deceased from <u>10/27, 1967</u> , to <u>10/27, 1967</u> that (I) (we) last saw the deceased alive on <u>10/27, 1967</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.                              |  |
| 22a. SIGNATURE <u>Robert R. Montgomery</u> M.D.  |                                   | 22b. DATE SIGNED <u>10/27/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT R. MONTGOMERY</u>   |                                   | 22d. ADDRESS <u>5411 CEDAR LAKE BETHESDA</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>10/31/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Woodland Cem.</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Xenia, Ohio</u>                 |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Md.</u>   |                                   | 25a. REC'D BY REGISTRAR <u>NOV 1 1967</u>  |  |
|  |                                   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

141114

141119

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. LENGTH OF STAY IN TB <u>8 days</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Salus Hospital</u>   |  | d. STREET ADDRESS <u>7017 Meadow Lane</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>William B. Ingersoll</u>  |  | 4. DATE OF DEATH <u>Oct 11 1967</u>  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-11-09</u> 9. AGE (In years last birthday) <u>58</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>William Sigelow Ingersoll</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Emma Harriet B. Belt</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>   |  | 16. SOCIAL SECURITY NO   |  |
| 17. INFORMANT <u>Consul</u> <u>C. S. Belt</u>  |  | Address <u>7021 Meadow Lane Chevy Chase, Md.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent and remote</u>  |  |  |  |
| DUE TO   |  |  |  |
| (b) <u>coronary arteriosclerosis with occlusion</u>  |  |  |  |
| DUE TO   |  |  |  |
| (c)  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street, office, etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 11 1967</u> to <u>Oct 11 1967</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Oct 11 1967</u> , and that death occurred at <u>11:27 A.M.</u> from causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE <u>Stewart Clapp</u>  |  | 22b. DATE SIGNED <u>Oct 11 1967</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>   |  | 22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF <u>10-14-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Perkins Chapel Cem.</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Springfield, Maryland</u>     |
| 24. FUNERAL DIRECTOR <u>ROBERT A. McPHEEY, Bethesda, Maryland</u>  |  | 25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>   | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14115

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1120

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>   |   |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Garthursburg</u>   |   |
| c. LENGTH OF STAY IN 1b<br><u>52 days</u>   |  | d. STREET ADDRESS<br><u>Box 273</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban Hospital</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Nathan</u> Middle <u>J</u> Last <u>Jackson</u>   |  | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>28</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>Negro</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>July 29, 1932</u>                                      |
| 9. AGE (In years last birthday)<br><u>35</u> yrs  |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>unemployed</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Nathan Jackson</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Martha Robinson</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |   |
| 17. INFORMANT<br><u>MARY Neal - (sister) Box 273</u>  |  | Address <u>Garthursburg, Md.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia Bronchial. confluent bilat.</u><br>DUE TO <u>9160</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Encephalo. Malacia</u><br>DUE TO <u>  </u><br>(c) <u>Burns of body</u>  |  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>52 days</u>   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>  </u>   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)<br><u>Fell asleep when smoking in bed.</u>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>11:30</u> pm <u>Sept 2</u> 19 <u>67</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><u>Home</u>   | 20f. (City or town) (County) (State)<br><u>Garthursburg Montgomery Md.</u>    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><u>John S. Ball</u> M.D.  |  | 22. DATE SIGNED<br><u>10/29/67</u>  |   |
| EXAMINER'S NAME (Type)<br><u>  </u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><u>  </u> |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE THEREOF<br><u>Nov. 4, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>John Wesley Cemetery</u>   | 23d. LOCATION (City or town) (County) (State)<br><u>Clarksburg Montg. Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Robert L. Luorden Rockville, Md.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>NOV 6 1967</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>                         |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 17-21 Film 393  
10-19-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14115

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14121

|  |                             |  |                                   |  |  |
|--|-----------------------------|--|-----------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>   |                             | c. LENGTH OF STAY IN 1b<br><b>SPENCERVILLE</b>   |                                   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>M.D.</b><br>b. COUNTY<br><b>MONTGOMERY</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SANITARIUM &amp; Hospital</b>  |                             | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | d. STREET ADDRESS<br><b>15419 BATSON ROAD</b>  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>ROBERT ALVIN JENKINS</b>   |                             | 4 DATE OF DEATH<br><b>10 6 1967</b>  |                                   | 5 AGE (in years last birthday)<br><b>25 yrs</b>  |  |
| 6 SEX<br><b>M</b>  | 7 COLOR OR RACE<br><b>W</b> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                         | 9 DATE OF BIRTH<br><b>1-13-42</b> | 10 F UNDER 1 YEAR<br>Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min <b>67</b>  | 11 IF UNDER 24 HRS<br>Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min <b>67</b>               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>skull metal worker</b>   |                             | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>same</b>   |                                   | 11 BIRTHPLACE (State or foreign country)<br><b>M.D.</b>  |  |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                             | 13 FATHER'S NAME<br><b>JOSEPH JENKINS</b>  |                                   | 14 MOTHER'S MAIDEN NAME<br><b>ROBERTA HAIRFIELD</b>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                             | 16 SOCIAL SECURITY NO<br><b>216-40-6679</b>  |                                   | 17 INFORMANT<br><b>DRIVERS LICENSE</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple skull fractures with</b><br>DUE TO <b>avulsion of cerebral substance</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>due to auto accident</b><br>(c) <b>due to auto accident</b>  |                             |  |                                   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                             |  |                                   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                             | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>deceased as passenger in auto when driver lost control and struck four trees.</b> |                                   |  | 20c. TIME OF INJURY Month, Day, Year<br><b>7:29 pm 10/6 1967</b>                                 |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Street</b>  |                                   | 20f. (City or town) (County) (State)<br><b>Silver Spring Montg Md</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                             |  |                                   |  |  |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b>  |                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                   | 22. DATE SIGNED<br><b>Oct. 7, 1967</b>   |  |
| EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP M.D.</b>   |                             | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                   | Address (City or town, county)<br><b>Baltimore Md</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                             | 23b. DATE THEREOF<br><b>Oct 9, 1967</b>  |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Union Cemetery</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md</b>   |                             | 24 FUNERAL DIRECTOR<br><b>John Walters, 234 Carroll Ave. Wash DC</b>   |                                   | 25a. REC'D BY REGISTRAR<br><b>OCT 11 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                             |  |                                   |  |  |





14117

## CERTIFICATE OF DEATH

14122

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> <u>Silver Spring</u><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>                  |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring Md.</u>  |  | c LENGTH OF STAY IN 1b<br><u>10 days</u>  |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Fairland Nursing Home</u>  |  | d STREET ADDRESS<br><u>8625 Piney Branch Road</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Elmer Johnson</u>  |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>29</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/7/70</u>   |
| 9. AGE (In years lost birthday)<br><u>97</u> yrs   |  | 10. IF UNDER 1 Year<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>  |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired printer G.P.O.</u>  |  | 12. KIND OF BUSINESS OR INDUSTRY<br><u>Norway</u>   |   |
| 13. FATHER'S NAME<br><u>Unknown</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO<br><u>578-44-3191</u>  |   |
| 17. INFORMANT<br><u>A Dorothy K. Nichols</u>   |  | 18. ADDRESS<br><u>90 Hedin Dr. Silver Spring, Md.</u>   |   |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u><br><u>4200</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>a congestive failure</u><br>(c) <u>1 day</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Tumor? left lower lobe</u>   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 29</u> , 19 <u>67</u> to <u>Oct 29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Oct 29</u> , 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above  |  |   |   |
| 22a. SIGNATURE<br><u>Merton Z. White</u>   |  | 22b. DATE SIGNED<br><u>29 Oct 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Merton Z. White</u>   |  | 22d. ADDRESS<br><u>9911 Georgia Ave., Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>11/1/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Prince Georges County</u> |
| 24. FUNERAL DIRECTOR<br><u>SH HINES Co.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>NOV 1 1967</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  | 25c. ADDRESS<br><u>2901 145TH AVE</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M. Z. White, D.O. covering for R. Benesh, D.O. please sign as physician

100



100

100



14123

24. FUNERAL DIRECTOR

VR A15 (4)  
25M 1/67

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

141119

141124

|  |                                 |  |   |
|--|---------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Virginia</b><br>b. COUNTY                              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |                                 | c. LENGTH OF STAY IN 1b<br><b>MARTINSVILLE</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Althea Woodland Nursing Home</b>  |                                 | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>ELIZABETH W. JOHNSTON</b>   |                                 | 4 DATE OF DEATH<br>Month <b>Oct.</b> Day <b>19</b> Year <b>67</b>  |   |
| 5 SEX<br><b>Female</b>   | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>June 27, 1886</b> |
| 9 AGE (In years last birthday) yrs <b>81</b>   |                                 | 10 IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>  |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                 | 10b KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |   |
| 11 BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13 FATHER'S NAME<br><b>Stafford G. Whittle</b>   |                                 | 14 MOTHER'S MAIDEN NAME<br><b>Ruth R. Drewry</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                 | 16 SOCIAL SECURITY NO<br><b>no</b>   |   |
| 17 INFORMANT<br><b>Whittle Johnston Chevy Chase, Md.</b>   |                                 | Address  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b><br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c) <b>Chronic nephritis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                                 |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic nephritis</b>   |                                 |  |   |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b><br>p.m.  |                                 | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                 |  |   |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b> M.D.   |                                 | 22. DATE SIGNED<br><b>10/20/67</b>   |   |
| EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP, M.D.</b>  |                                 | Address (State, city or town, or county)   |   |
| 23a. BIRTH REFORMATORY REMOVAL (Specify)   |                                 | 23b. DATE THEREOF<br><b>Oct. 23, 1967</b>  |   |
| 23c. NAME OF "METHY" OR CREMATORY<br><b>Fairview Cemetery</b>  |                                 | 23d. LOCATION (City or town) (County) (State)<br><b>Roanoke, Virginia</b>  |   |
| 24. NAME OF REGISTRAR<br><b>Robert A. Pumphrey</b>   |                                 | 25a. REC'D BY REG. STRAR<br><b>BETHESDA, MD.</b>   |   |
| 25b. REG. STRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                 | DATE<br><b>OCT 25 1967</b>   |   |



CERTIFICATE OF DEATH

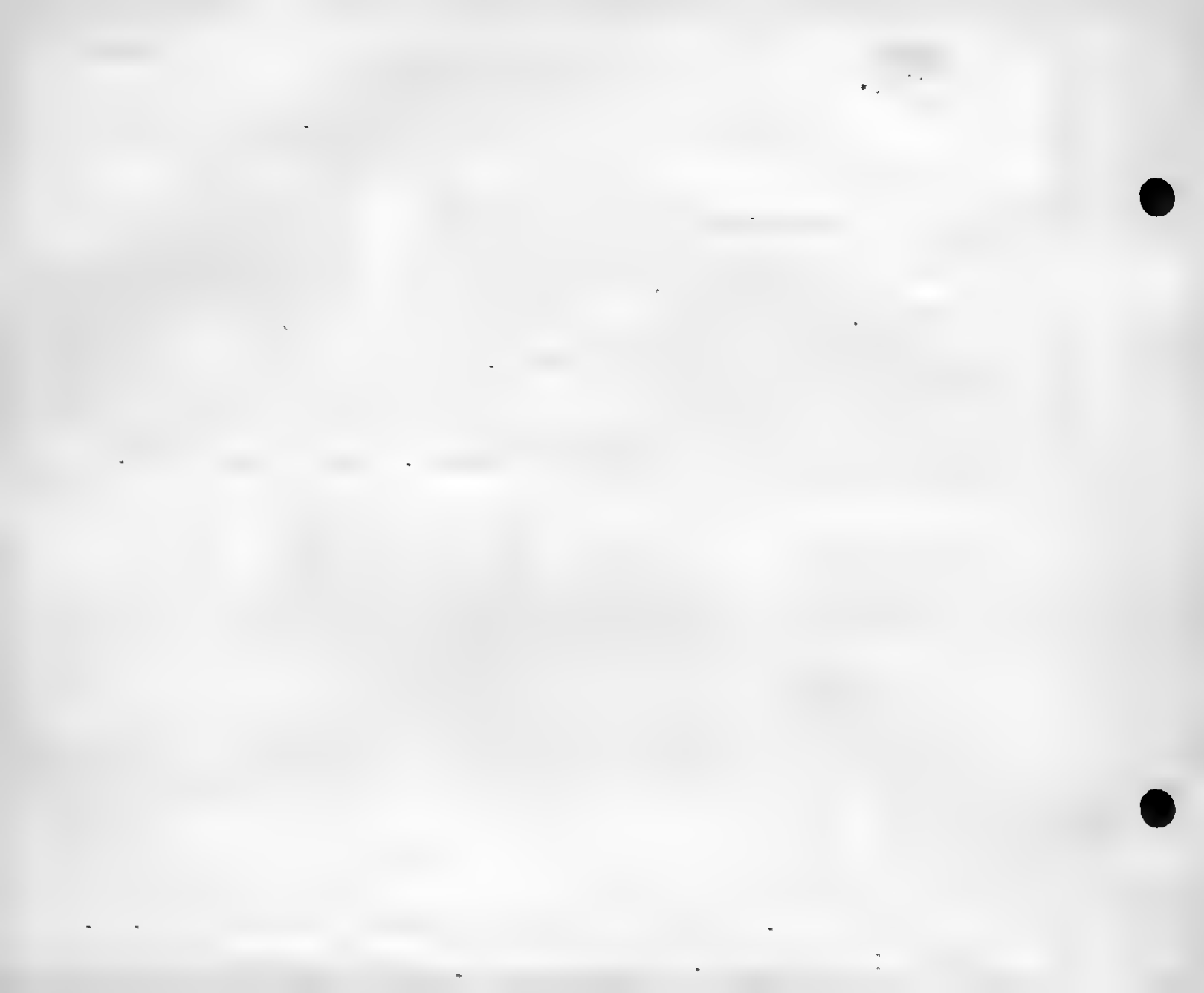
14120

14125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if at institution, give name, before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>   |  |
| c. LENGTH OF STAY IN 1b <u>2 days</u>  |  | d. STREET ADDRESS <u>8101 15th Ave</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>Robert Saunders Jones</u>  |  | 4 DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>  |  |
| 5 SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/11/91</u>  |
| 9 AGE (In years last birthday) <u>76</u> yrs.  |  | 10 UNDER 1 YEAR Months <u>  </u> Days <u>  </u>   | 11 UNDER 24 HRS Hours <u>  </u> Min <u>  </u>                              |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAPER SALES MAN</u>  |  | 10b KIND OF BUSINESS OR INDUSTRY <u>Virginia Paper Co. Penna</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Robert S. Jones -</u>   |  | 14. MOTHER'S MAIDEN NAME <u>MARTHA Templar</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO <u>577-03-3559-A</u>   |  |
| 17 INFORMANT <u>Frances H. Jones</u>   |  | 18. ADDRESS <u>8101 - 15th Avenue Hyattsville, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cerebral Atherosclerosis</u><br>LEOX DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Diabetic mellitus</u><br>DUE TO (c) <u>Cerebral Atherosclerosis</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u><br><u>5-8 yrs</u><br><u>5-8 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 2</u> , 1957, to <u>Oct 4</u> , 1967, that (I) <u>we</u> last saw the deceased alive on <u>Oct 4</u> , 1967, and that death occurred at <u>10:20 AM</u> from causes and on the date stated above   |  |   |  |
| 22a SIGNATURE <u>W.B. Wardrop MD</u>   |  | 22b DATE SIGNED <u>10/5/67</u>  |  |
| 22c PHYSICIAN'S NAME (Type) <u>W.B. WARDROP, MD</u>  |  | 22d ADDRESS <u>808 PERSHING Dr. Silver Spring Md</u>  |  |
| 23a BURIAL CREMATON, REMOVAL (Specify)   | 23b DATE THEREOF <u>Oct 7, 1967</u>  | 23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>  | 23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u> |
| 24 FUNERAL DIRECTOR <u>Thomas E. Pumphrey, Inc.</u>  |  | 25a REC'D BY REGISTRAR <u>8474 Geo gia Avenue Silver Spring, Md.</u>  |  |
| 25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>  |  | DATE <u>OCT 9 1967</u>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

Cleared with Dr. B. Reap - apparently natural cause

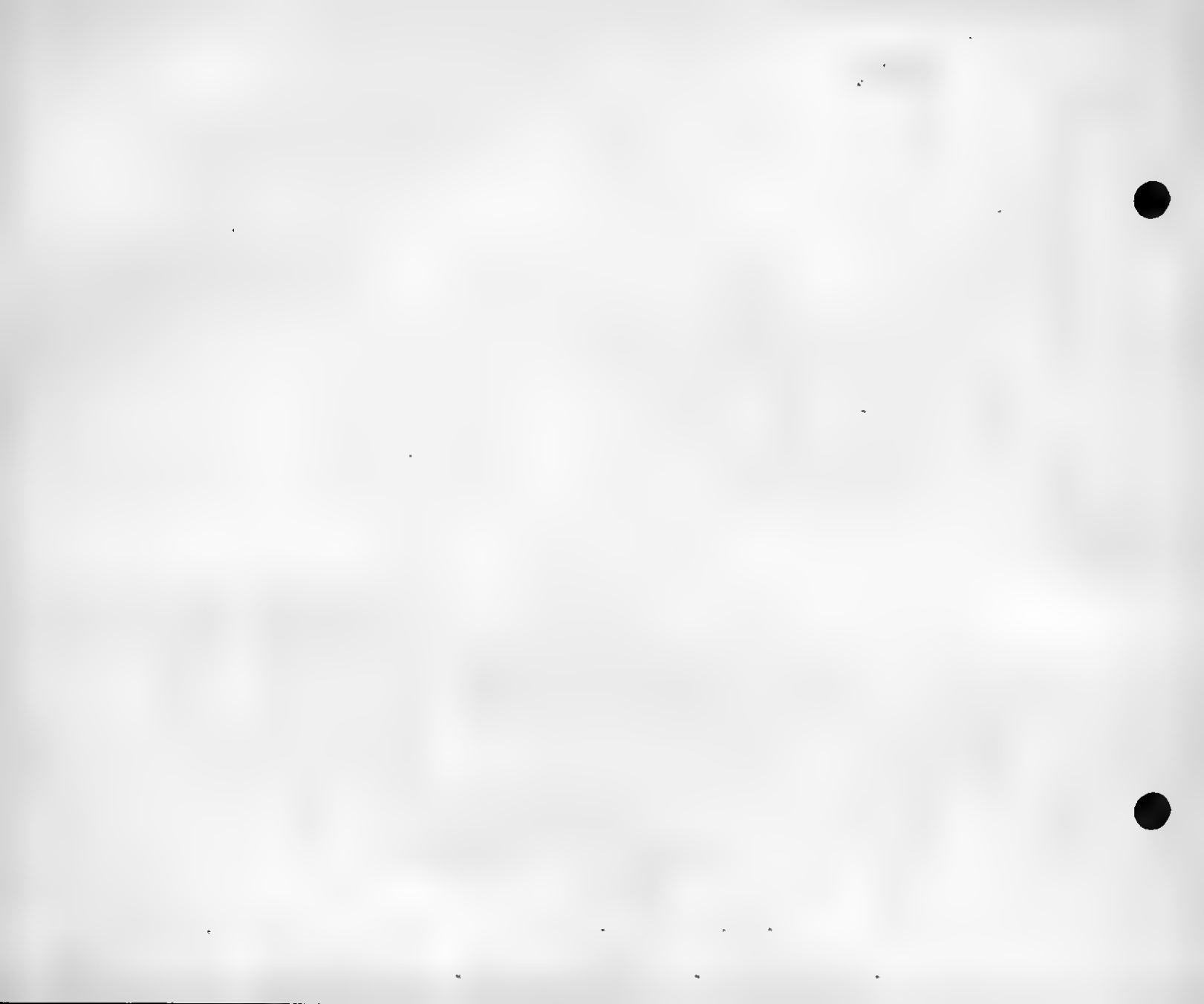
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1-1126

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  | MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission)<br>a. STATE<br>Maryland   |  | b. COUNTY<br>Montgomery   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Silver Spring  |  | c. LENGTH OF STAY IN 1b<br>hours  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Silver Spring,   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Holy Cross Hospital  |  |   |  | d. STREET ADDRESS<br>122 Lynmoor Dr. SS Md.  |  |   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Dennis N Jordan  |  |   |  | 4 DATE OF DEATH<br>Month Day Year<br>10 27 19 67   |  |   |  |
| 5 SEX<br>Male  |  | 6 COLOR OR RACE<br>White  |  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br>7/22/08  |  |
| 9 AGE (in years last birthday)<br>59 yrs   |  | 10 IF UNDER 1 YEAR<br>Months Days Hours M n   |  | 11 BIRTHPLACE (County & State, or foreign country)<br>Virginia   |  | 12 CIT ZEN OF WHAT COUNTRY?<br>USA  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>clerk  |  |   |  | 10b KIND OF BUSINESS OR INDUSTRY<br>US Post Office   |  |   |  |
| 13 FATHER'S NAME<br>Frank B. Jordan  |  |   |  | 14 MOTHER'S MAIDEN NAME<br>Bessie Gregory  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br>yes WW II   |  | 16 SOCIAL SECURITY NO<br>226-07-1909  |  | 17 INFORMANT<br>Address<br>wife A.B. Jordan 122 Lynmoor Dr. SSMd.  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) 4201 Acute coronary thrombosis<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>Undetermined  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |   |  |
| 20c TIME OF INJURY Month, Day Year<br>Hour a.m. p.m. 19  |  | 20d INJURY OCCURRED<br>While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>                          |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from September, 1967, to October 27, 1967, that (I) (we) last saw the deceased alive on September 1967, and that death occurred at 10:00 AM, from causes and on the date stated above.                                    |  |   |  |  |  |   |  |
| 22a SIGNATURE<br>Bennet A. Porter Jr.  |  | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  | 22b DATE SIGNED<br>October 27, 1967  |  |   |  |
| 22c PHYSICIAN'S NAME (Type)<br>Bennet A. Porter, Jr.   |  | 22d ADDRESS<br>Harmon 9301 Coleridge Rd., Silver Spring, Md.  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b DATE THEREOF<br>Oct. 30, 1967   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Comfort Cemetery  |  | 23d LOCATION (City or Town) (County) (State)<br>Alexandria, Virginia                              |  |
| 24 FUNERAL DIRECTOR<br>Warner E. Humphrey, Inc.  |  | ADDRESS<br>JB Thomas, 8434 Georgia Ave.   |  | 25a REC'D BY REGISTRAR<br>NOV 2 1967   |  | 25b REGISTRAR'S SIGNATURE<br>John A. Judge  |  |



14122

CERTIFICATE OF DEATH

1-1127

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)<br>a. STATE <b>WASH. D.C.</b><br>b. COUNTY                             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WHEATON</b>  |   | c. LENGTH OF STAY IN 1b<br><b>57 MONTHS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WHEATON NURSING HOME<br/>11901 GEORGIA AVE.</b>  |   | d. STREET ADDRESS<br><b>3033 WEST LANE KEYS N.W.</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>MARIE ANTOINETTE JORDAN</b>  |   | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>9</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-28-1873</b>  |
| 9. AGE (in years last b rthday)<br><b>94</b> yrs  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>FRANCE</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>BLESBOIS DESIRE</b>   |   | 14. MOTHER'S MAIDEN NAME  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>F.C.D. Jordan-son</b>   |   | Address <b>SAME 2d</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>General Visceral Failure</b><br>DUE TO (b) <b>Generalized Arteriosclerosis</b><br>DUE TO (c) <b>Senility</b>                        |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 1961</b> to <b>Oct 9 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept 26 1967</b> , and that death occurred at <b>1130P.M.</b> from causes and on the date stated above. |   |   |   |
| 22a. SIGNATURE<br><b>Francis E. Sharpe</b>  |   | 22b. DATE SIGNED<br><b>10-9-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Francis E. Sharpe</b>  |   | 22d. ADDRESS<br><b>4105 Wisconsin Ave. Wash D.C.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   | 23b. DATE THEREOF<br><b>10-10-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>                          |
| 24. FUNERAL DIRECTOR<br><b>Lee Funeral Home</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 13 1967</b>  |   |
| ADDRESS<br><b>Washington, D.C.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

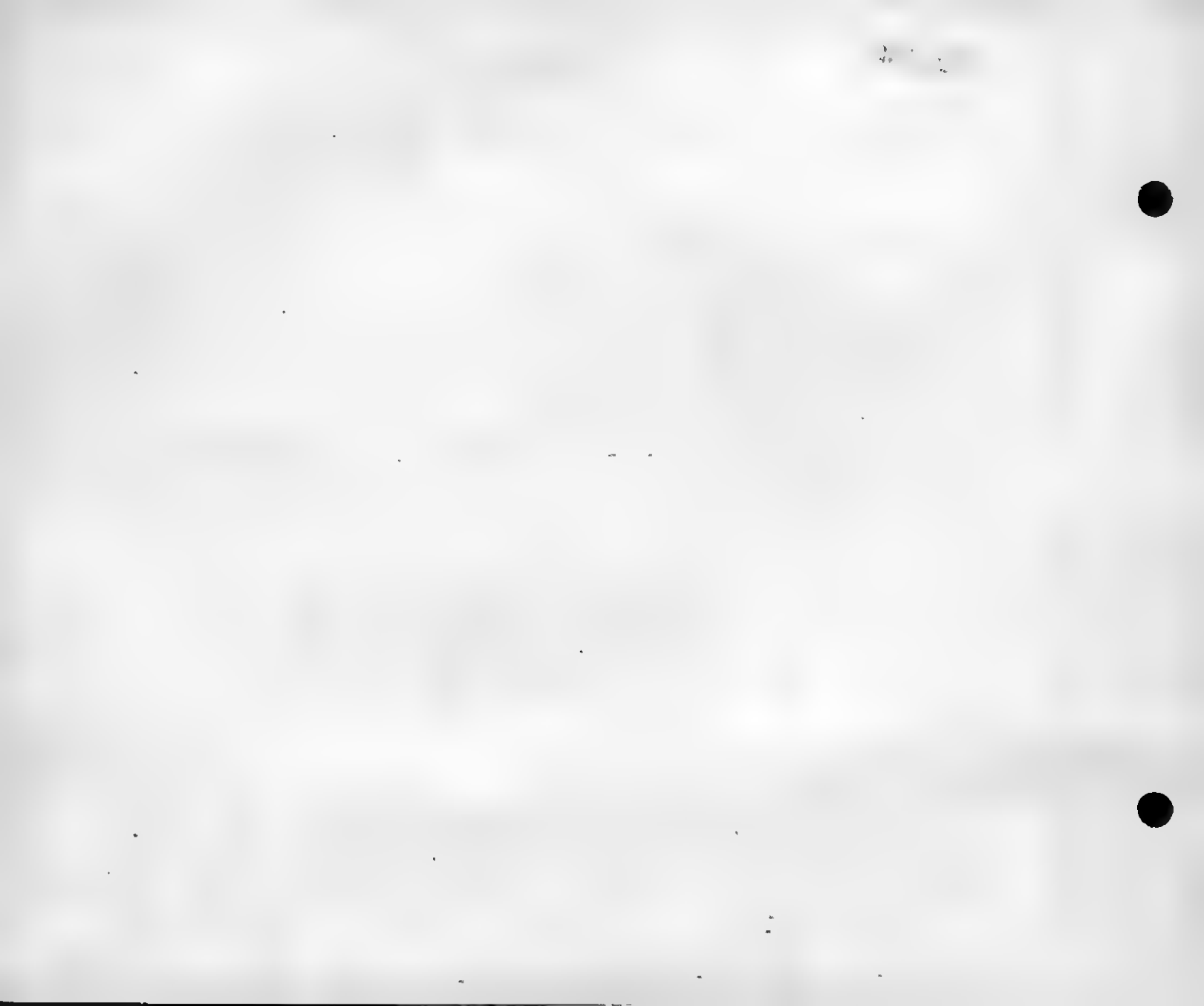


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VR A15 (4)  
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |   |                                       |   |   |   |
|--|--|---|--|--|---|---------------------------------------|---|---|---|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |                                       |   |   |   |
| Item #16 Film #335 11/23/67  |  |   |  |  |   |                                       |   |   |   |
| 14122 CERTIFICATE OF DEATH 14128   |  |   |  |  |   |                                       |   |   |   |
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |                                       |   |   |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>  |  |   | c LENGTH OF STAY IN 1b <u>3 years</u>  |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |                                       |   |   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>   |  |   |  |  | d STREET ADDRESS <u>1019 Nora Drive</u>   |                                       |   | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED (Type or print) <u>Catherine Mary Judy</u>  |  |   |  |  | 4 DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1967</u>  |                                       |   |   |   |
| 5 SEX <u>Female</u>  |  | 6 COLOR OR RACE <u>white</u>                      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8 DATE OF BIRTH <u>Sept. 18, 1888</u> |   | 9. AGE (In years last birthday) <u>79</u> yrs.  |   |
| 10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> |  | 11 BIRTHPLACE (County & State or foreign country) <u>Youngstown, Ohio</u>  |   |                                       | 12 CIT ZEN OF WHAT COUNTRY? <u>U.S.A.</u>                               |   |   |
| 13. FATHER'S NAME <u>James A. Hennessy</u>   |  |   |  |  | 14. MOTHER'S MAIDEN NAME <u>Mary Clark</u>  |                                       |   |   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>  |  | 16 SOCIAL SECURITY NO <u>978-09-9220</u>          |  | 17 INFORMANT <u>Catherine J. Long</u> Address <u>4305 Elmwood Road Beltsville, Maryland</u>  |   |                                       |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myofascitic pneumonia (terminal)</u><br>DUE TO (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Parkinsonian Syndrome</u>               |  |   |  |  |   |                                       |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |                                       |   |   | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |                                       |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |   | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                       | 20f. (City or town) (County) (State)                                    |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/26, 1966</u> to <u>10/29/67, 1967</u> , that (I) (we) last saw the deceased alive on <u>10/29, 1967</u> , and that death occurred at <u>6:30 AM</u> , from causes and on the date stated above |  |   |  |  |   |                                       |   |   |   |
| 22a. SIGNATURE <u>R.C. Kirchner</u>  |  |   |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>        |                                       | 22b. DATE SIGNED <u>Oct. 29, 1967</u>                                   |   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>R.C. KIRCHNER</u>  |  |   |  |  | 22d ADDRESS <u>6480 N.H. Ave - TAKOMA PARK. Md.</u>   |                                       |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>Nov 31, 1967</u>             |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>  |   |                                       | 23d. LOCATION (City or Town) (County) (State) <u>Switland, Maryland</u> |   |   |
| 24 FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> Address <u>8434 Georgia Avenue Silver Spring, Md.</u>  |  |   |  |  | 25a. REC'D BY REGISTRAR <u>NOV 1 1967</u>   |                                       | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                         |   |   |



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14129

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>University Nursing Home</u>  |   | d. STREET ADDRESS<br><u>10500 Rockville pike</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Alice</u> Middle <u>B.</u> Last <u>Keenan</u>   |   | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>17</u> Year <u>19 67</u>   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Caus.</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/5/1910</u>                                      |
| 9. AGE (In years last birthday)<br><u>57</u> yrs.   |   | IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Buffalo, New York</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>William Boughton</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Fellows</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO.<br><u>220-44-6615</u>   |  |
| 17. INFORMANT<br><u>Lawrence Keenan, Son, 273 Congressional La.,</u>  |   | Address <u>Rockville, Md.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Breast, c Metastases</u><br><u>110X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DUE TO</u><br>(c) <u>DUE TO</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1967</u> to <u>10/17/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/17/67</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><u>Henry C. Scruggs, M.D.</u>   |   | 22b. DATE SIGNED<br><u>10/17/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>HENRY C. SCRUGGS, M.D.</u>   |   | 22d. ADDRESS<br><u>5413 Cedar Lane Bethesda Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify)  | 23b. DATE THEREOF<br><u>10/20/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Forest Lawn Cemetery</u>   | 23d. LOCATION (City, town or county) (State)<br><u>Buffalo, New York</u> |
| 24. FUNERAL DIRECTOR<br><u>Joseph G. Lawrence, San Diego - Wash., D.C.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DET 19 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Richard Judge</u>  |   |   |  |





FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14125

|   |   |   |  |
|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ROCKVILLE</b><br>c. LENGTH OF STAY IN 1b<br><b>4 YRS</b>   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ROCKVILLE</b> |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>CATHERINE B. KENNEDY</b>  |   | 4 DATE OF DEATH<br>Month Day Year<br><b>OCT. 26 1967</b>  |  |
| 5 SEX<br><b>FEMALE</b>  | 6 COLOR OR RACE<br><b>WHITE</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>7-30-24</b><br>9 AGE (In years last birthday) yrs<br><b>43</b> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |   | 10b KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   | 11 BIRTHPLACE (State or foreign country)<br><b>SCOTLAND</b>                          |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 13 FATHER'S NAME<br><b>John BLACK</b>   |  |
| 14 MOTHER'S MAIDEN NAME<br><b>MARIAN SHAW</b>   |   | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |
| 16 SOCIAL SECURITY NO<br><b>113-24-0145</b>   |   | 17 INFORMANT<br><b>HUSBAND (WILTON L) SAME</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>4201 Acute coronary insufficiency;</b><br>(and if any, which gave rise to immediate cause (a), stating the underlying cause lost.)<br>(b) <b>Rheumatic heart disease</b><br>(c)   |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a);<br><b>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>   |   |   |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c TIME OF INJURY Month Day, Year<br>Hour a.m. pm 19   | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b><br>EXAMINER'S NAME (Type)<br><b>BELOEN R. REAP, M.D.</b>  |   | 22 DATE SIGNED<br><b>10/26/1967</b>   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  | 23b DATE THEREOF<br><b>Oct. 30, 1967</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Parlawn Cemetery</b>  | 23d LOCATION (City or Town) (County) (State)<br><b>Rockville, Maryland</b>           |
| 24a ADDRESS<br><b>C. Glen Carter, 2401 E. Pimlico, Silver Spring, Md.</b>   |   | 25a REC'D BY REGISTRAR<br><b>NOV 2 1967</b>   | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                    |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14128

14131

|   |                                  |  |  |
|---|----------------------------------|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u><br>c. LENGTH OF STAY IN 1b <u>6 Years</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Belmont Nursing Home</u> |                                  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>M</u> b. COUNTY <u>District of Columbia</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u><br>d. STREET ADDRESS <u>3805 T Street, N. W.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>ANNIE</u><br>First Middle Last  |                                  | <b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>1</u> Year <u>1967</u>  |  |
| <b>5. SEX</b> <u>Fe</u>   | <b>6. COLOR OR RACE</b> <u>W</u> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b> <u>April 15, 1882</u>          |
| <b>9. AGE</b> (In years last birthday) <u>85</u> yrs.   |                                  | <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>   | <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u> |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>house wife</u>  |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Ireland</u>  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.</u>  |                                  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>  |  |
| <b>13. FATHER'S NAME</b> <u>Cryan</u>   |                                  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>  |                                  | <b>16. SOCIAL SECURITY NO.</b> <u>  </u>   |  |
| <b>17. INFORMANT</b> <u>SON</u> Address <u>11815 Anid Dr. Potomac, Md.</u>  |                                  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION</u><br>DUE TO (b) <u>CORONARY ARTERIOSCLEROSIS</u><br>(c) <u>GEN'L ARTERIOSCLEROSIS</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>OSTEOPOROSIS</u> <u>ARTHRITIS</u>   |                                  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |                                  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u>   |                                  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Mar 1964 to 10/1/67</u>  |                                  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Mar 1964 to 10/1/67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>9/30/1967</u> , <b>and that death occurred at</b> <u>5 P.M.</u> , <b>from the causes and on the date stated above.</b>   |                                  |  |  |
| <b>22a. SIGNATURE</b> <u>Donald R. Lewis</u>  |                                  | <b>22b. DATE SIGNED</b> <u>10/1/67</u>   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>DONALD R. LEWIS</u>  |                                  | <b>22d. ADDRESS</b> <u>700 CLOVERLY SIL SPRING MD</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>  |                                  | <b>23b. DATE THEREOF</b> <u>10-4-67</u>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u>  |                                  | <b>23d. LOCATION</b> (City, town or county) (State) <u>Washington, D. C.</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUM</u>  |                                  | <b>25a. REC'D BY REGISTRAR</b> <u>OCT 6 1967</u>   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>  |                                  | <b>25c. ADDRESS</b> <u>Bethesda, Maryland</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14127

14132

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dickerson, Md</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dickerson, Md (Rural)</b>  |  |
| c. LENGTH OF STAY IN 1b<br><b>Yrs</b>  |  | d. STREET ADDRESS   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Richard</b> Middle <b>E.</b> Last <b>King</b>  |  | 4. DATE OF DEATH<br>Month <b>Oct</b> Day <b>8</b> Year <b>67</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/24/1878</b>                                  |
| 9. AGE (in years last birthday)<br><b>88</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days  | 11. IF UNDER 24 HRS<br>Hours Min.                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>Horace King</b>   |  |
| 14. MOTHER'S M A DEN NAME<br><b>Unknown</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |
| 16. SOCIAL SECURITY NO   |  | 17. INFORMANT Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>October, 1960</b> , to <b>8 Oct., 1967</b> , that (I) (we) last saw the deceased alive on <b>7 October 1967</b> , and that death occurred at <b>9:51 A.M.</b> from causes and on the date stated above.                           |  |   |  |
| 22a. SIGNATURE<br><b>Gordon M. Smith</b>   |  | 22b. DATE SIGNED<br><b>8 Oct 67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Gordon M. Smith, M.D.</b>   |  | 22d. ADDRESS<br><b>Barnesville, Maryland, 20703</b>   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10/11/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Mt. Zion, Md.</b>  |
| 24. FUNERAL DIRECTOR<br><b>Robert L. Snowden</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 10 1967</b>  |  |
| ADDRESS<br><b>Rockville, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>   |  |



## CERTIFICATE OF DEATH

14128

14133

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |  | c. LENGTH OF STAY IN 1b<br><u>2 days</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanatorium &amp; Hospital</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Ignazio Frank LA CAVERA</u>  |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>24</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>Cauc.</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-14-01</u>                 |
| 9. AGE (In years last birthday)<br><u>66</u> yrs   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Barber</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>self-employed</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Italy</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>Amer</u>   |  |
| 13. FATHER'S NAME<br><u>Salvatore LA CAVERA</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Vincinetta Sperandio</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO<br><u>577-09-8112</u>  |  |
| 17. INFORMANT<br><u>Patients Chart</u>   |  | Address <u>674</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO (b) _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO (b) _____<br>(c) _____ |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)               |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 2</u> , 1954, to <u>Oct 24</u> , 1967, that (I) (the) last saw the deceased alive on <u>24 Oct 1967</u> , and that death occurred at <u>11:08 PM</u> , from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><u>W. R. Wardrop MD</u>  |  | 22b. DATE SIGNED<br><u>Oct 24, 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>W. R. Wardrop</u>   |  | 22d. ADDRESS<br><u>808 Pershing Drive Silver Spring, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><u>Oct. 27, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven Cemetery Silver Spring, Md.</u>   | 23d. LOCATION (City or Town) (County) (State)      |
| 24. FUNERAL DIRECTOR'S NAME (Type)<br><u>Charles Judge</u>   |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |
| DATE <u>OCT 27 1967</u>  |  |   |  |



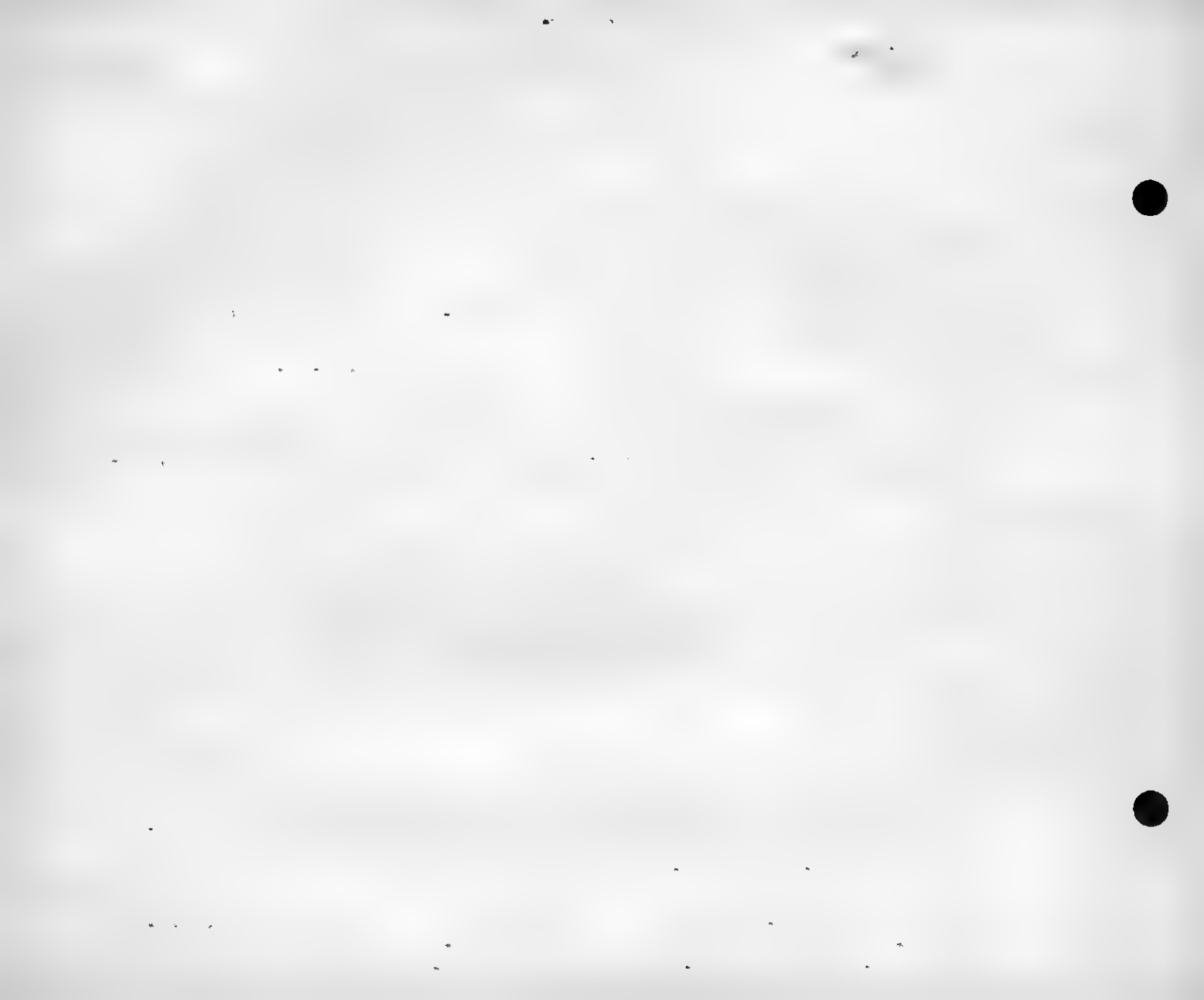


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |  |
| 14128 CERTIFICATE OF DEATH 14134  |  |  |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville Silver Spring</b>  |  |  | c. LENGTH OF STAY IN 1b                              |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>  |  |  |  |   | d. STREET ADDRESS<br><b>13810 Congress Drive</b>   |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Lottie Marion Lamb</b>  |  |  |  |   | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>28</b> Year <b>1967</b>   |   |  |   |  |
| 5. SEX<br><b>female</b>   |  | 6. COLOR OR RACE<br><b>white</b>         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 6, 1885</b>   |  | 9. AGE (in years)<br><b>82</b> (month) <b>8</b> (days)  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D. C.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>John Joseph Phillip</b>   |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Carrie Cunningham</b>   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |  | 16. SOCIAL SECURITY NO<br><b>579-18-9746</b>         |   | 17. INFORMANT<br><b>Lewis J Lamb/son</b> Address <b>7513 Maple Avenue, Takoma Park, Md.</b>  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO (b) <b>Hypertension</b><br>DUE TO (c) <b>Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Arteriosclerosis</b>  |  |  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> to <b>28 Oct, 1967</b> , that (I) (we) lost the deceased alive on <b>Aug 1967</b> , and that death occurred at <b>3:17 PM</b> from causes on and on the date stated above   |  |  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>William D. And</b>   |  |  |  |   | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>             |   | 22b. DATE SIGNED<br><b>Oct. 28, 1967</b>           |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. William D. And</b>   |  |  |  |   | 22d. ADDRESS<br><b>Colesville, Road Silver Spring, Md</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Nov. 1, 1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>        |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b>   |  |  |  |   | 25a. REC'D BY REGISTRAR<br><b>NDV 1 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14130

CERTIFICATE OF DEATH

14135

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRINGS</b>   |   | c. LENGTH OF STAY IN 1b<br><b>CHEVY CHASE</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>CHEVY CHASE NURSING &amp; CONVALESCENT CENTER</b>  |   | d. STREET ADDRESS<br><b>4615 HUNT AVENUE</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>ELIZABETH LANE</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>OCTOBER 11 19 67</b>   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPT. 14, 1884</b>                                   |
| 9. AGE (In years lost birthday)<br><b>83</b> yrs  |   | IF UNDER 1 YEAR<br>Months Days Hours Min  | IF UNDER 24 HRS<br>Months Days Hours Min                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>KENTUCKY</b>      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |   |   |
| 13. FATHER'S NAME<br><b>EDWARD WRING</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>BELLE PERRY</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>NURSING &amp; CONVALESCENT CENTER RECORDS</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Meningitis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <u>Cerebral Thrombosis</u><br>(c) <u>Generalized Arterio Sclerosis</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 months</u><br><u>years</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS A JPTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (the hospital) attended the deceased from <u>Oct -</u> , 19 <u>67</u> , to <u>date</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>10 Oct</u> 19 <u>67</u> , and that death occurred at <u>6:15 AM</u> from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><u>John G. Ball</u>   |   | 22b. DATE SIGNED<br><u>Oct. 11, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John G. Ball</u>   |   | 22d. ADDRESS<br><u>7936 Georgetown Rd. Bethesda Md</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>10/13/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HIGHLAND CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>SOUTH BEND, INDIANA</b> |
| 24. FUNERAL DIRECTOR<br><b>ROBERT E. WILHELM FUNERAL HOME</b><br><b>4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 13 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                          |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If July day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

| 14131   |                              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                               | 14136   |   |
|---|------------------------------|---|-------------------------------|---|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                              |   |                               |   |   |
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b><br>c. LENGTH OF STAY N 16 <b>DOA</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>  |                              | 2 USUAL RESIDENCE (Where deceased lived, 1 institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b><br>d. STREET ADDRESS <b>13009 Arctic Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Lewis</b> Middle <b>Phillip</b> Last <b>Lasher</b>   |                              | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>14</b> Year <b>1967</b>   |                               |   |   |
| 5 SEX <b>Male</b>   | 6 COLOR OR RACE <b>White</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH <b>8/7/27</b> | 9 AGE (in years last birthday) <b>40</b> yrs  | 10 UNDER 1 YEAR<br>Months <b>4</b> Days <b>10</b> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Govt. agent</b>   |                              | 10b KIND OF BUSINESS OR INDUSTRY <b>FDA Govt.</b>   |                               | 11 BIRTHPLACE (State or foreign country) <b>Denver, Colorado</b>                              |   |
| 13 FATHER'S NAME <b>Phil Lasher</b>   |                              | 14 MOTHER'S MAIDEN NAME <b>Grace Caldwell</b>   |                               | 12 CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. II</b>   |                              | 16 SOCIAL SECURITY NO <b>521-3-0895</b>   |                               | 17 INFORMANT <b>Wife, BeBe Lasher</b><br>Address <b>13009 Arctic Ave. Rockville, Md.</b>      |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART DEATH WAS CAUSED BY<br><b>4301</b><br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Coronary Artery Heart Disease</b><br>DUE TO<br>(c)   |                              | INTERVAL BETWEEN ONSET AND DEATH  |                               |   |   |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              |   |                               | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                              | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)  |                               |   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                              | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                               | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |   |
| 20f (City or town) (County) (State)   |                              |   |                               |   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |   |                               |   |   |
| ACTUAL SIGNATURE <b>Belden R. Heap</b><br>EXAMINER'S NAME (Type) <b>BELDEN R. HEAP M.D.</b>   |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (if free, city, county, and state)   |                               | 22. DATE SIGNED <b>Oct. 14, 1967</b>  |   |
| 23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                              | 23b DATE THEREOF <b>10-20-67</b>  |                               | 23c NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>                                  |   |
| 23d LOCATION (City or Town) (County) (State) <b>Denver, Colorado</b>  |                              |   |                               |   |   |
| 24 FUNERAL DIRECTOR <b>Robert A. Humphrey</b><br>Address <b>Pethesda, Maryland</b>  |                              | 25a REC'D BY REGISTRAR <b>OCT 16 1967</b>   |                               | 25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

14132

CERTIFICATE OF DEATH

14137

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA (rural)</b>   |   | c. LENGTH OF STAY IN lb<br><b>2 days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>US NAVAL HOSPITAL</b>  |   | d. STREET ADDRESS<br><b>5 TANNER AVE</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>MILTON</b> Last <b>LAUGHLIN</b>   |   | 4. DATE OF DEATH<br>Month <b>OCT</b> Day <b>13</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>CAUC</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 12TH 1924</b>   |
| 9. AGE (In years last birthday)<br><b>43</b> yrs  |   | 10. UNDER 1 YEAR<br>Months Days Hours Min.  | 11. UNDER 24 HRS<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U. S. NAVY</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>BESSEMER, ALA</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>NEWMAN HODGE LAUGHLIN</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>MINNIE LEE KIRK</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES 6-12-41 10/13/67</b>  |   | 16. SOCIAL SECURITY NO.<br><b>6-10 24 0199</b>  |   |
| 17. INFORMANT WIFE<br><b>MAY LAUGHLIN, 5 TANNER AVE, LEXINGTON PK, MD.</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO<br>(c)       |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11 OCT.</b> , 19 <b>67</b> , to <b>13 OCT.</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>13 OCT.</b> , 19 <b>67</b> , and that death occurred at <b>9:28 PM</b> , from causes and on the date stated above. |   |   |   |
| 22a. SIGNATURE<br><i>Jack E. Zimmerman</i>  |   | 22b. DATE SIGNED<br><b>14 OCT 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JACK E. ZIMMERMAN</b>  |   | 22d. ADDRESS<br><b>NAVAL HOSPITAL, BETHESDA, MD.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>10-17-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL CEMETERY, ARLINGTON, VIRGINIA</b>   |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>ARLINGTON, VIRGINIA</b>   |   | 23e. REC'D BY REGISTRAR<br><b>OCT 23 1967</b>   |   |
| 23f. REGISTRAR'S SIGNATURE<br><i>Robinson Funeral Home</i>  |   | 23g. REGISTRAR'S SIGNATURE<br><i>Robinson Funeral Home</i>  |   |

23a. BURIAL, CREMATION, REMOVAL (Specify)  
**BURIAL**

23b. DATE THEREOF  
**10-17-67**

23c. NAME OF CEMETERY OR CREMATORY  
**ARLINGTON NATIONAL CEMETERY, ARLINGTON, VIRGINIA**

23d. LOCATION (City or Town) (County) (State)

23e. REC'D BY REGISTRAR  
**OCT 23 1967**

23f. REGISTRAR'S SIGNATURE





# 1

## FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, it may be executed by a physician or other person designated by the State Board of Health. This certificate is necessary for the funeral director to file with the State Board of Health. It should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

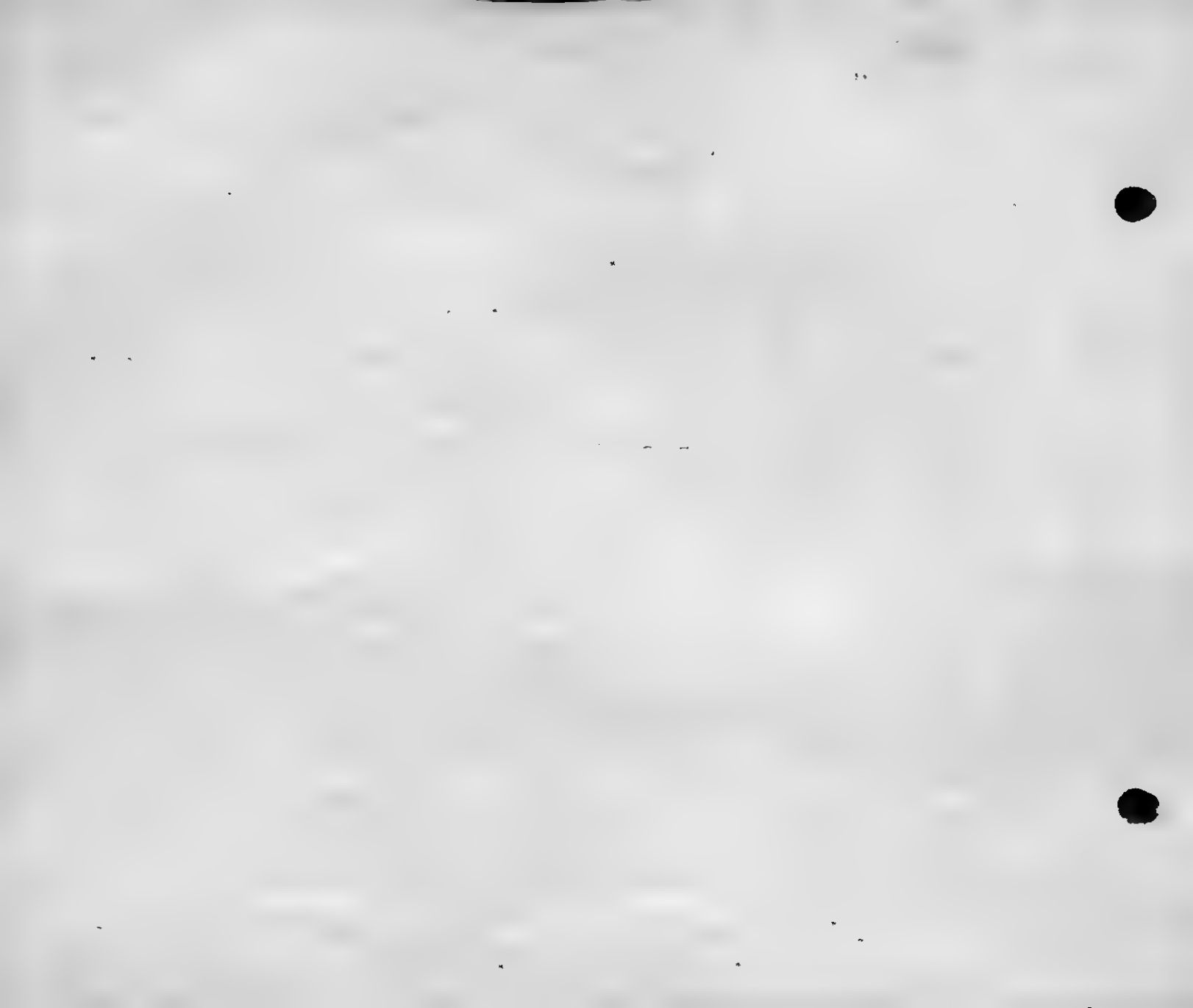
VS. A15ME  
5M 7/59

### Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# 1-1138

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u><br>c. LENGTH OF STAY IN 1b <u>3 years</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12704 Helen Road</u>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u><br>d. STREET ADDRESS <u>12704 Helen Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Margaret</u> Middle <u>E.</u> Last <u>Ledford</u>  |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>3</u> Year <u>1967</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>Nov. 20, 1889</u>                  |
| 9. AGE (In years last birthday) <u>77</u> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   | 11. IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |
| 13. FATHER'S NAME <u>Jackson Wingate</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Laura Cashion</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>578-05-0676D</u>  |  |
| 17. INFORMANT <u>Virginia Ramsay</u>   |   | 18. ADDRESS <u>12704 Helen Road Wheaton, Maryland</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u><br>4201 DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u><br>PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |   |  |  |
| ACTUAL SIGNATURE <u>Belden R. Read</u>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |   | 22b. DATE THEREOF <u>Oct. 6, 1967</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>  |   | 22d. LOCATION (City, town, or country) (State) <u>Prince Georges County, Md.</u>   |  |
| 23. GENERAL DIRECTOR'S ADDRESS <u>C. Glen Carter 8434 Georgia Avenue Warner E. Humphrey, Inc. Silver Spring, Md.</u>   |   | 24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>   |  |
| DATE <u>OCT 9 1967</u>   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

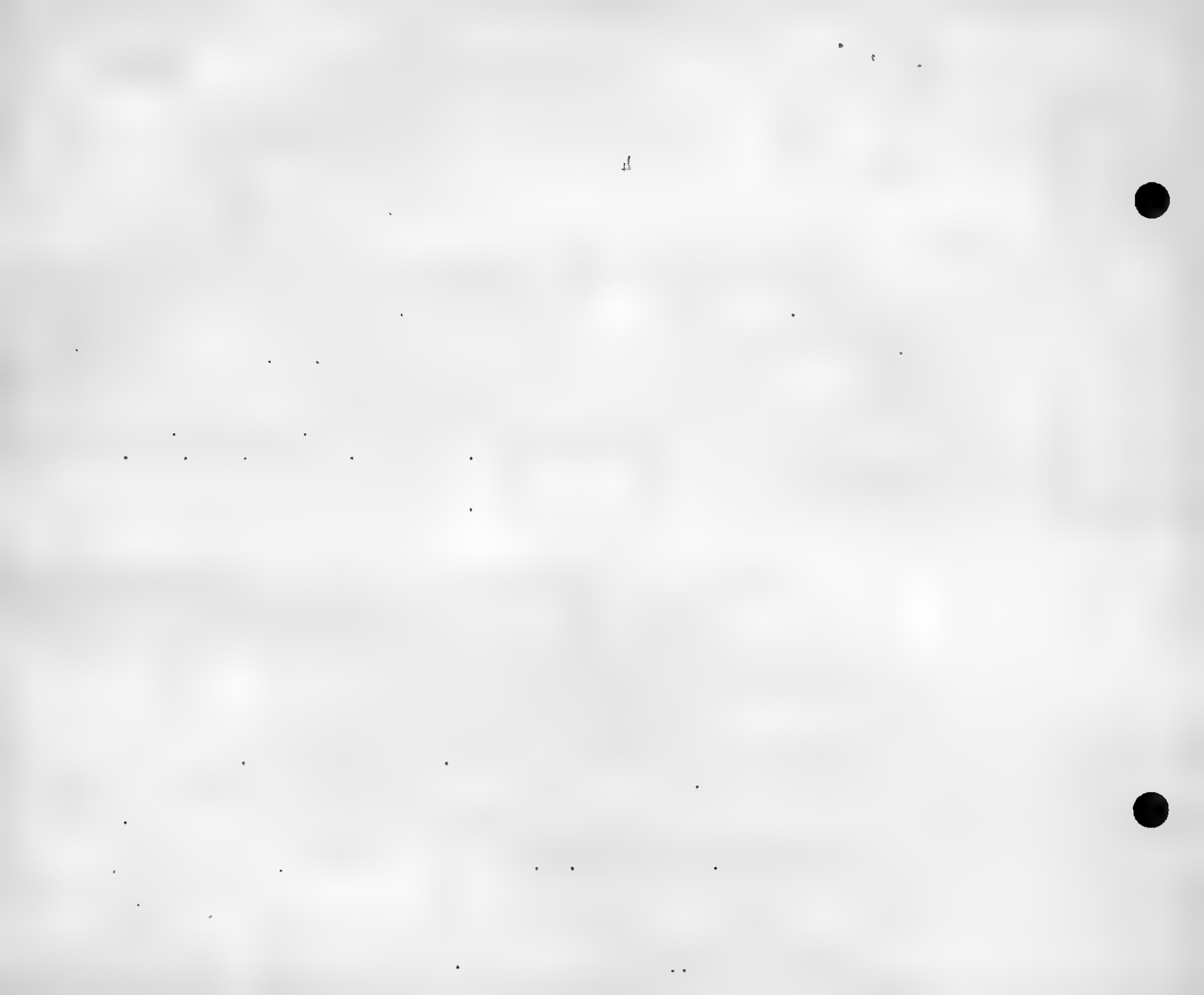
14134

CERTIFICATE OF DEATH

14139

|  |  |   |   |
|--|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <input checked="" type="checkbox"/> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>  |  | c. LENGTH OF STAY IN 1b<br><b>4 days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>  |  | e. STREET ADDRESS<br><b>2406 Fort Scott Drive</b>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Ethel</b> Middle <b>Jeanne Davis</b> Last <b>LEGGETT</b>  |  | 4 DATE OF DEATH<br>Month <b>October</b> Day <b>5</b> Year <b>19 67</b>  |   |
| 5 SEX<br><b>Female</b>   | 6 COLOR OR RACE<br><b>Cauc.</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH<br><b>March 13, 1899</b>                                   |
| 9. AGE (In years last birthday) yrs.<br><b>68</b>  |  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>19</b> Hours <b>67</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |   |
| 11 BIRTHPLACE (County & State or foreign country)<br><b>Falls Church, Va.</b>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Eugene Davis</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Blanch Gott</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>230 30 9107</b>   |   |
| 17 INFORMANT<br><b>Scott Drive, Arlington, Virginia</b>  |  | <b>Capt. Aubrey B. Leggett, USN, Ret. 2406 Fort</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cerebral infarction, right</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 1</b> , 19 <b>67</b> , to <b>Oct. 5</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 5</b> , 19 <b>67</b> , and that death occurred at <b>1105M</b> , from causes and on the date stated above. |  |   |   |
| 22a SIGNATURE<br><i>Lawrence W. Raymond</i>  |  | 22b DATE SIGNED<br><b>Oct. 6 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lawrence W. Raymond, M. D.</b>  |  | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>10-9-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington, Virginia</b> |
| 24. FUNERAL DIRECTOR<br><b>Pearsons Funeral Home</b>   |  | 25a. RECEIVED BY REGISTRAR<br><b>1967</b>   |   |
| <b>472 North Washington St., Falls Church, Va.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |

OCT 9 1967



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

14135

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14140

|  |                                 |  |                                   |
|--|---------------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>DAMASCUS</b>  |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MONTGOMERY GENERAL HOSPITAL</b>   |                                 | d. STREET ADDRESS<br><b>25913 REVA DRIVE</b>   |                                   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>THOMAS</b> Middle <b>MILLER</b> Last <b>LEISHEAR</b>  |                                 | 4 DATE OF DEATH<br>Month <b>10</b> Day <b>30</b> Year <b>19 67</b>   |                                   |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>WHITE</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>5-12-99</b> |
| 9 AGE (in years lost birthday)<br><b>68</b> yrs  |                                 | 10 F UNDER 1 YEAR<br>Months <b>10</b> Days <b>30</b> Hours <b>19</b> Min <b>67</b>   |                                   |
| 11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |                                 | 11b KIND OF BUSINESS OR INDUSTRY<br><b>FARMER</b>  |                                   |
| 12 BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                 | 13 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                   |
| 14 FATHER'S NAME<br><b>THOMAS MILLER LEISHEAR, Sr.</b>   |                                 | 15 MOTHER'S M maiden NAME<br><b>MARY FRANCES MOLESWORTH</b>  |                                   |
| 16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                 | 17 SOC. A. SECURITY NO.<br><b>577-26-9465A</b>   |                                   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>4201</b><br>DUE TO<br>(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.)<br>(b) <b>Acute Coronary Insufficiency</b><br>(c) <b>Coronary Artery (Heart) Disease</b>  |                                 | INTERVAL BETWEEN ONSET AND DEATH   |                                   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                 |  |                                   |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                 | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  |                                   |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f (City or town) (County) (State)  |                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                 |  |                                   |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b><br>EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP M.D.</b>  |                                 | 22. DATE SIGNED<br><b>10/30/1967</b>   |                                   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b DATE THEREOF<br><b>11-2-67</b>   |                                   |
| 23c NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel</b>   |                                 | 23d LOCATION (City or town) (County) (State)<br><b>Sunshine Mont. Md.</b>  |                                   |
| 24 FUNERAL DIRECTOR<br><b>Francis H. Barber Laytonsville, Md.</b>  |                                 | 25a REC'D BY REGISTRAR<br><b>NOV 2 1967</b>  |                                   |
| 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                 |  |                                   |

Body released p/o Dr. Reap



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14111

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WHEATON</u><br>c. LENGTH OF STAY IN 1b<br><u>4 months</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>RANDOLPH HILLS NURSING HOME - 4011 Randolph Rd.</u>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><u>MARYLAND</u><br>b. COUNTY<br><u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ROCKVILLE</u><br>d. STREET ADDRESS<br><u>329 West Edmonston Drive</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>ANNA D. LELAND</u>  |                                  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>31</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>FEMALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>MAY 17, 1879</u> |
| 9. AGE (In years last birthday)<br><u>88</u> yrs   |                                  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>NEW YORK CITY</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Robert Ross</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Eleanor Duby</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>084-03-1367-D</u>  |   |
| 17. INFORMANT<br><u>Harris D. Leland</u>   |                                  | 18. ADDRESS<br><u>329 West Edmonston Dr. Rockville, Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>1530</u><br>DUE TO <u>  </u><br>(b) <u>  </u><br>DUE TO <u>  </u><br>(c) <u>CARCINOMA OF THE CECUM - metastasizing</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>  </u> |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |                                  | 20f. (City or town) (County) (State)<br><u>  </u>   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 30, 1967</u> , to <u>OCT 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT 27, 1967</u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><u>Benne G. Bendlar</u>  |                                  | 22b. DATE SIGNED<br><u>10-31-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Benne G. Bendlar</u>  |                                  | 22d. ADDRESS<br><u>10820 Georgia Ave Wheaton, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Trans-burial</u>   |                                  | 23b. DATE THEREOF<br><u>Nov. 2, 1967</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Evergreens Cemetery</u>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Kinas County New York</u>   |   |
| 25a. REC'D BY REGISTRAR<br><u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |





FOR STATE  
HEALTH DEPT

14137

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14142

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  | c. LENGTH OF STAY IN 1b<br><u>6 Mo.</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chesapeake</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Bethesda Silver Spring Nursing Home</u>   |  | d. STREET ADDRESS<br><u>7103 Brennan Lane</u>  |   |
| 3 NAME OF DECEASED (Type or print) <u>Ruth</u> First Middle Last <u>M. Lingamfelter</u>  |  | 4 DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1967</u>  |   |
| 5 SEX <u>Fe.</u>   | 6 COLOR OR RACE <u>W.</u>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Jan 8, 1882</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9 AGE (in years last birthday) <u>85</u> yrs  |
| 11 BIRTHPLACE (State or foreign country)<br><u>Penna.</u>  |  | 12 CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Sam Montanye</u>   |  | 14. MOTHER'S MAIDEN NAME   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |   |
| 17. INFORMANT <u>Son</u> Address <u>Amarillo, Tex.</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>   |   |
| DUE TO (b) <u>Cardio Vascular Disease -</u>  |  | Years <u>4</u>   |   |
| DUE TO (c)   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/11/67</u>  |   |
|  |  | Address (Street, city, town, or county) <u>Bethesda, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>10-13-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Glenwood Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D. C.</u>                             |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |  | 25a. REC'D BY REGISTRAR<br><u>OCT 16 1967</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

1-11-43

14139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |  |  |
|---|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery Co.</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Washington, District of Columbia</u><br>b. COUNTY <u>Washington, District of Columbia</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u>  |   | c. LENGTH OF STAY IN 1b<br><u>3 yrs.</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Potomac Valley Nursing Home</u>  |   | d. STREET ADDRESS<br><u>4709 Yuma St. N.W.</u>   |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Charles</u> First <u>E.</u> Middle <u>Lund</u> Last  |   | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>24</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                   | 8. DATE OF BIRTH<br><u>4/12/86</u>                                     |
| 9. AGE (In years last birthday)<br><u>81</u> yrs  |   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Economist</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Gov't.</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>New York, New York</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Harold Lund</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Marat</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u> <u>1919</u>   |   | 16. SOCIAL SECURITY NO.<br><u>  -  -  -  </u>  |  |
| 17. INFORMANT<br><u>Eleanor C. Lund</u>   |   | Address <u>4709 Yuma St. Washington, D.C.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of B. Ladder</u><br>DUE TO (b) <u>CVA</u><br>DUE TO (c) <u>Uremia</u>   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>  </u>   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>  </u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  | 20f. (City or town) (County) (State)<br><u>  </u>                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 10</u> , 19 <u>64</u> to <u>Oct. 24</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Oct. 24</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M., from causes and on the date stated above. |   |  |  |
| 22a. SIGNATURE<br><u>Robert A. Macon</u> M.D.   |   | 22b. DATE SIGNED<br><u>10/24/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. Robert C. Macon,</u>   |   | 22d. ADDRESS<br><u>809 Veirs Mill Road, Rockville, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   | 23b. DATE THEREOF<br><u>10-27-1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenwood Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Brooklyn, N.Y.</u> |
| 24. FUNERAL DIRECTOR<br><u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>  </u> DATE <u>OCT 26 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |  |  |



14139

## CERTIFICATE OF DEATH

14144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pupers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>  |   | d. STREET ADDRESS<br><b>9005 Colesville Road</b>  |   |
| 3 NAME OF DECEASED (Type or print) <b>John Joseph LUSBY</b>  |   | 4 DATE OF DEATH<br>Month <b>Oct.</b> Day <b>12</b> Year <b>19 67</b>  |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>Cauc</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>March 4, 1901</b>                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U. S. Navy</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <b>66</b> yrs                               |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Montgomery Co., Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13 FATHER'S NAME<br><b>George Lowther Lusby</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Estella Windham</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1919-1948</b>  |   | 16 SOCIAL SECURITY NO. <b>579-18-9773</b>   |   |
| 17. INFORMANT <b>Rd., Silver Spring, Md.</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Left Upper Lobe</b><br>DUE TO (b) <b>Chronic Lymphocytic leukemia</b><br>DUE TO (c) <b></b> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 14</b> , 19 <b>67</b> , to <b>Oct. 12</b> , 19 <b>67</b> , that (we) last saw the deceased alive on <b>Oct. 12</b> , 19 <b>67</b> , and that death occurred at <b>145A</b> M, from causes on and the date stated above. |   |   |   |
| 22a SIGNATURE<br><i>David L. Foreman</i>   |   | 22b. DATE SIGNED<br><b>Oct. 13, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>David L. Foreman</b>  |   | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Oct. 17, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington, Virginia</b> |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey Funeral Home</b>   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 19 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>John A. Judge</i>                          |
| 26. ADDRESS<br><b>8434 Georgia Ave., Silver Spring, Md.</b>  |   |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

- Cause of death called - learned

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                      |   |   |  |   |   |  |  |
|---|--|--------------------------------------|---|---|--|---|---|--|--|
| 14140   |  |                                      |   |   |  |   |   |  |  |
| CERTIFICATE OF DEATH  |  |                                      |   |   |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |                                      |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |  |                                      | c. LENGTH OF STAY IN 1b<br><u>42 days</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u>                  |   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital</u>  |  |                                      |   |   | d. STREET ADDRESS<br><u>4201 Massachusetts Ave. NW</u>   |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>ALICE</u>  |  | First                                |   | Middle<br><u>L.</u>   |  | Last<br><u>LYONS</u>                    |   | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>25</u> Year <u>1967</u>                           |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>     |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Apr. 15-1891</u> |   | 9. AGE (in years last birthday)<br><u>76</u> yrs   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY    |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Boston, Massachusetts</u>   |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |  |
| 13. FATHER'S NAME<br><u>Michael Cummings</u>  |  |                                      |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Brigid Joyce Cummings</u>   |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><u>No</u>   |  |                                      | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><u>Silver Spring, Md.</u><br><u>Mr. Arthur V. Dieli, 2020 Hanover St.</u>                             |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Longstanding heart failure</u><br>DUE TO (b) <u>ATHEROSCLEROSIS</u><br>DUE TO (c) <u>Age</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                      |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Fracture of T. Twelfth &amp; T. Thip</u>  |  |                                      |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><u>PT fell down stairs</u> |   |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.  |  |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)<br><u>Home</u>                                   |   | 20f. (City or town) (County) (State)<br><u>Washington, D.C.</u> <u>Montgomery</u> <u>D.C.</u> |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-13-67</u> , 19 <u>67</u> , to <u>10-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-24</u> , 19 <u>67</u> , and that death occurred at <u>8:35 AM</u> , from causes and on the date stated above.                               |  |                                      |   |   |  |   |   |  |  |
| 22a. SIGNATURE<br><u>Henry William Jaeger</u>   |  |                                      |   |   | 22b. DATE SIGNED<br><u>10-25-67</u>  |   |   | 22c. PHYSICIAN'S NAME (Type)<br><u>Henry W. Jaeger</u>   |  |
| 22d. ADDRESS<br><u>1015 Spring St., Silver Spring, Md.</u>  |  |                                      |   |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>10-28-67</u> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Seaside Cemetery</u>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Lanesville, Massachusetts</u>             |  |  |
| 24. FUNERAL DIRECTOR<br><u>Rinaldi Funeral Home, 7400 Georgia Ave, NW</u>   |  |                                      |   |   | 25a. REC'D BY REGISTRAR<br><u>DATE OCT 31 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14146

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b><br>c. LENGTH OF STAY IN 1b<br><b>1 DAY</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SAN &amp; Hosp.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b><br>d. STREET ADDRESS<br><b>FAIRLAND NURSING HOME</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>CLARENCE LEROY MAISACK</b>  |  | 4. DATE OF DEATH<br>Month <b>OCT.</b> Day <b>21</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>JULY 30, 1894</b>                                     |
| 9. AGE (In years lost birthday) yrs<br><b>73</b>   |  | 10. IF UNDER 24 HRS<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED TRACKMAN</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>PRIVATE UTILITY</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>HAGERSTOWN, MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>JACOB F. MAISACK</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>MAMIE ENGLEBRIGHT</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO<br><b>219-54-2258</b>   |  |
| 17. INFORMANT<br><b>Hosp. Records</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary insufficiency</b><br><b>4201</b><br>DUE TO<br>(b) <b>Coronary artery heart disease</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c)  |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b> M.D.<br>EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town or county)<br><b>10/21/1967</b>   |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><b>CREMATION</b>  | 23b. DATE THEREOF<br><b>10/24-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEMETERY</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>WASHINGTON 23, D. C.</b> |
| 24. FUNERAL DIRECTOR<br><b>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND</b>   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 30 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14142

14147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>D. C.</b> b. COUNTY <b>---</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>                               |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Carroll Hall Sanitarium</b>   |  |   |  | d. STREET ADDRESS<br><b>638 A St., NE</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BERTRAM</b> Middle <b>MAJOR</b> Last <b>MAJOR</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>11</b> Year <b>1967</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 7, 1891</b> | 9. AGE (In years last birthday)<br><b>76</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>---</b> Days <b>---</b>                         | IF UNDER 24 HRS.<br>Hours <b>---</b> Min. <b>---</b>  | 10. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Machinist</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Navy Yard</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>William Major</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Grimes</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>548-50-0489</b>   |  | 17. INFORMANT<br><b>Ac#2 Tangle Lane #2 Mrs. Dorothy Hoover, Wantagh, LI, NY</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b><br>DUE TO (b) <b>CHRONIC MYOCARDITIS</b><br>DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL SCLEROSIS</b> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 HOURS</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b>---</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)                      | (County)  | (State)  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 26, 1967</b> to <b>OCTOBER 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 11, 1967</b> , and that death occurred at <b>4:30 M.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><i>Henry J. Leland</i>   |  |   |  | 22b. DATE SIGNED<br><b>10-11-67</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Henry J. Leland</b>  |  |
| 22d. ADDRESS<br><b>5206 Norway Dr. Chevy Chase, Ind.</b>   |  |   |  | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>10/13/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>  | 23d. LOCATION (City, town or county)     | (State)   | 23e. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE<br><b>Wm. Lees Sons</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>J. Wm. Lees Sons; Washington, DC</b>  |  |   |  | 25a. DATE<br><b>OCT 16 1967</b>   |  |   |  |



14148

14143

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |   | c. LENGTH OF STAY IN 1b <u>3 MONTHS</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>  |   | d. STREET ADDRESS <u>13508 Crispin Way</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>William J. Mancusi</u>   |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>19</u> Year <u>1967</u>   |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/17/23</u>  |
| 9. AGE (In years last birthday) <u>44</u> yrs  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Representative</u>                                    |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Philip Mancusi</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Ada Conklin</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Army - WWII</u>   |   | 16. SOCIAL SECURITY NO. <u>65-12-080</u>  |  |
| 17. INFORMANT <u>MRS. JOAN MANCUSI</u>   |   | Address <u>13508 Crispin Way, Rockville, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Brain &amp; Lung Complication</u><br>DUE TO (b) <u>due to Malignant</u><br>DUE TO (c) <u>Glioma of Brain of Brain</u>           |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1967</u> to <u>Oct 19, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 18, 1967</u> and that death occurred at <u>6:40 AM</u> , from causes and on the date stated above. |   |   |  |
| 22a. SIGNATURE <u>John Thomas Head</u>   |   | 22b. DATE SIGNED <u>10/19/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>John Thomas Head</u>   |   | 22d. ADDRESS <u>1015 Spring St Silver Spring, Maryland</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF <u>10/23/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>  | 23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville, Pike</u>  |   | 25a. REC'D BY REGISTRAR <u>OCT 23 1967</u>  | 25b. REGISTRAR'S SIGNATURE <u>William J. Head</u>                            |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery County</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hopkittsville</u>  |  |
| c. LENGTH OF STAY IN 1b <u>3 hours 45 min</u>   |  | d. STREET ADDRESS <u>2600 Queens Chapel Rd apt 810</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Sam (Hons) Mandel</u>  |  | 4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1967</u>   |  |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/2/21</u>   |
| 9. AGE (In years last birthday) <u>46</u> yrs   |  | 10. IF UNDER 1 YEAR Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housing Urban Development U.S govt</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>7-4</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  | 13. FATHER'S NAME <u>Mandel</u>  |  |
| 14. MOTHER'S MAIDEN NAME <u>?</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Army 1942-2</u>                           |  |
| 16. SOCIAL SECURITY NO <u>052 12 8845</u>   |  | 17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201</u><br>DUE TO (b) <u>Acute Myocardial Infarction</u><br>DUE TO (c) <u>Coronary Sclerosis</u>                                |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS</u><br><u>5 years</u>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction in 1965</u>  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1967, to <u>10/22</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/20</u> , 1967, and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above |  |  |  |
| 22a. SIGNATURE <u>Samuel Dessoff</u>  |  | 22b. DATE SIGNED <u>10/23/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>SAMUEL DESSOFF</u>  |  | 22d. ADDRESS <u>1302-18 ST. N.W. WASH. D.C.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 23b. DATE THEREOF <u>OCT 27, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM</u>   | 23d. LOCATION (City or town) (County) (State) <u>BALTIMORE, MARYLAND</u>                       |
| 24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO.</u>  |  | 25a. REC'D BY REGISTRAR <u>Riverdale, Md.</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  | DATE <u>OCT 27 1967</u>  |  |

14144

14149





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66



14145

CERTIFICATE OF DEATH

14150

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>             |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chest Chase</u>  |  | c LENGTH OF STAY IN 1b<br><u>26 yrs</u>   | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chest Chase, Md.</u> |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>3713 Williams Lane</u>   |  | d STREET ADDRESS<br><u>3713 Williams Lane</u>   | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |
| 3 NAME OF DECEASED (Type or print) <u>INTERBOCK</u> First Middle Last <u>Mary</u>  |  | 4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>19 67</u>   |  |
| 5 SEX <u>Female</u>  | 6. COLOR OR RACE <u>WHITE</u>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>June 3 1899</u>   |
| 9 AGE (In years last birthday) <u>68</u> yrs   |  | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Germany</u>                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 13. FATHER'S NAME<br><u>Fritz Papendieck</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Toni Papendieck</u>   |  | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>                                     |  |
| 16. SOCIAL SECURITY NO.<br><u>579-44-7568</u>  |  | 17 INFORMANT Address <u>3713 Williams LA. Ch Ch. Md.</u><br><u>Fritz Karl Mann</u>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>LIVER Failure</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <u>CARCINOMA OF COLON</u><br>DUE TO<br>(c) |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 mo.</u><br><u>2 1/2 yrs</u>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>None</u>   |  |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>10/8</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>67</u> and that death occurred at <u>5 A</u> M, from causes and on the date stated above.                            |  |   |  |
| 22a. SIGNATURE<br><u>Edgar H. Levin</u> M.D.   |  | 22b. DATE SIGNED<br><u>10/8/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>EDGAR H. LEVIN</u>  |  | 22d. ADDRESS<br><u>8218 Wisconsin, Bethesda</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>10-11-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D. C.</u>                                  |
| 24 FUNERAL DIRECTOR<br><u>ROBERT A. FUMHREY, Bethesda, Maryland</u>  |  | 25a REC'D BY REGISTRAR<br>DATE <u>OCT 16 1967</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b><br>c. LENGTH OF STAY IN 1b<br><b>15 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington Sanitarium and Hospital</b> |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale</b><br>d. STREET ADDRESS<br><b>4310 Queensbury Road</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Max John Mathews</b><br>First Middle Last  |   | 4 DATE OF DEATH<br><b>October 31 19 67</b><br>Month Day Year   |   |
| 5 SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>3-2-11</b><br>9 AGE (In years last birthday)<br><b>56</b> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Real Estate Salesman</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Utah</b>   |   |
| 11 BIRTHPLACE (County & State or foreign country)<br><b>Utah</b>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>America</b>  |   |
| 13. FATHER'S NAME<br><b>Thomas Mathews</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Griffiths</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |   | 16 SOCIAL SECURITY NO<br><b>578-28-8494</b>  |   |
| 17. INFORMANT<br><b>Patinet's chart</b>  |   | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Neurologic Disease, Etiology Unclear</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)<br>DUE TO (c)                          |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic Urinary Tract Infection</b>  |   |  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)  | 20f (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10-15, 1967</b> , to <b>10-31, 1967</b> , that (I) (we) last saw the deceased alive on <b>10-30</b> 19 <b>67</b> , and that death occurred at <b>6:10</b> A.M., from causes and on the date stated above  |   |  |   |
| 22a SIGNATURE<br><b>George M. Grames</b> M.D.  |   | 22b DATE SIGNED<br><b>Oct 31, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>George M. Grames</b>  |   | 22d. ADDRESS<br><b>hospital Takoma Park, Md.</b>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>Nov 3, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maple Grove Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Farmer City Illinois</b>        |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |   | 25a REC'D BY REGISTRAR<br>DATE <b>NOV 2 1967</b>   |   |
|  |   | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14152

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>WEST VIRGINIA</b> b. COUNTY  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>  |   | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MONTGOMERY GENERAL HOSPITAL</b>  |   | e. STREET ADDRESS<br><b>-</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>RUSSELL (NMN) McCLELLAND</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>10 18 67</b>   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                             | 8. DATE OF BIRTH<br><b>6-2-16</b>  |
| 9. AGE (In years last birthday) yrs<br><b>51</b>  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BROOKLYN, WEST VIRGINIA</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>ALONZO McCLELLAND</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>ELLA COPELAND</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>MEDICAL RECORD DEPT.</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter on only one cause per line, for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary Artery Heart Disease</b><br>(c)   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M. D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>10/18/1967</b> |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>  | 23b. DATE THEREOF<br><b>Oct. 19 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wallace Memorial</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Clintonville West Virginia</b> |
| 24. FUNERAL DIRECTOR<br><b>Francis H. Barber Laytonville Md</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DATE OCT 23 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |

7. The following information is for your information:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

VR A15 (4)  
25M 1/67

14148

1-1153

CERTIFICATE OF DEATH

|  |                           |   |   |   |  |  |  |
|--|---------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLARKSBURG</b>   |                           |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLARKSBURG MD</b> |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RT #1 Box 129,</b>   |                           |   |   | d. STREET ADDRESS <b>RT #1 Box 129</b>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>HERMAN FOSTER McDONALD</b>   |                           |   |   | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>19</b> Year <b>1967</b>  |  |  |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>12/25/06</b>  | 9. AGE (In yrs. mos. days) <b>60/6/11</b>   | 10. IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>19</b>                 |  | 11. IF UNDER 24 HRS<br>Hours <b>19</b> Min <b>67</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE WK. STATE ROADS</b>   |                           |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>   |   | 11. BIRTHPLACE (County & State or foreign country) <b>U.S.</b>         |  |  |
| 13. FATHER'S NAME <b>Clarence McDonald</b>   |                           |   | 14. MOTHER'S MAIDEN NAME <b>Julia Clipper</b>   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                           |   | 16. SOCIAL SECURITY NO  |   | 17. INFORMANT <b>Mrs. Matilda McDONALD CLARKSBURG MD</b>               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO<br>(b) <b>Arteriosclerotic CARDIOVASCULAR disease</b><br>DUE TO<br>(c) <b>10 YRS</b>  |                           |   |   |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>Nephrosclerosis</b>  |                           |   |   |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)                |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                           |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |  |
| 20f. (City or town) (County) (State)   |                           |   | 20g. (City or town) (County) (State)  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/10</b> , 19 <b>67</b> to <b>10/15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10/15</b> , 19 <b>67</b> , and that death occurred at <b>8 P.M.</b> from causes on and on the date stated above. |                           |   |   |   |  |  |  |
| 22a. SIGNATURE <b>Melvin J. Kordon</b>   |                           |   | 22b. DATE SIGNED <b>10/19/67</b>  |   | 22c. PHYSICIAN'S NAME (Type) <b>MELVIN JOEL KORDON MD</b>              |  |  |
| 22d. ADDRESS <b>13 Deer Park Dr, GAITHERSBURG MD</b>   |                           |   | 22e. ADDRESS  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                           |   | 23b. DATE THEREOF <b>10/22/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Sugarland Cem.</b>               |  |  |
| 23d. LOCATION (City or Town) (County) (State) <b>Sugarland Montg. Md.</b>  |                           |   | 23e. LOCATION (City or Town) (County) (State)   |   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Robert L. Suunden Rockville, Md.</b>   |                           |   | 25a. REC'D BY REGISTRAR <b>DATE OCT 20 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>                        |  |  |





## CERTIFICATE OF DEATH

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Washington, D.C.</u> b. COUNTY                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |   | c. LENGTH OF STAY IN 1b<br><u>14 Days</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>   |   | d. STREET ADDRESS<br><u>1316 Van Buren Street, N.W.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Mamie</u> Middle <u>Marie</u> Last <u>McGill</u>  |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>14</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>Negro</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>15 October 1914</u>  |
| 9. AGE (In years last birthday)<br><u>52</u> yrs   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Shipper</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Virginia</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>George Thomas Bowe</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Lessie Arnold</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO<br><u>181-22-5077</u>  |   |
| 17. INFORMANT<br><u>The Medical Records</u>  |   | 18. ADDRESS<br><u>The Clinical Center, Bethesda, Maryland</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute systemic vasculitis</u><br>DUE TO<br>(b) <u>Acute Myocardial infarction</u><br>DUE TO<br>(c) <u>Sjogren's syndrome</u>   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>9 Days</u><br><u>9 Days</u><br><u>Unknown</u>              |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>30 Sept.</u> , 19 <u>67</u> , to <u>14 Oct.</u> , 19 <u>67</u> that <u>(X)</u> (we) last saw the deceased alive on <u>14 October 1967</u> , and that death occurred at <u>9:00 M.</u> from causes and on the date stated above |   |   |   |
| 22a. SIGNATURE<br><u>J. T. Willerson</u>   |   | 22b. DATE SIGNED<br><u>14 October 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>James T. Willerson, MD.</u>   |   | 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><u>10-18-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Restland Mem. Park</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Wilmerding, Pa. Allegheny County</u>          |
| 24. FUNERAL DIRECTOR<br><u>Stewart Funeral Home 4001 Benning Rd.</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 17 1967</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 5, and page 6, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14150

## CERTIFICATE OF DEATH

14155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY COUNTY</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)<br>a. STATE <b>VIRGINIA</b><br>b. COUNTY                             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |   | c. LENGTH OF STAY IN 1b<br><b>1 MONTH</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNANDALE</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Bethesda Naval Hospital</b>  |   | d. STREET ADDRESS<br><b>7719 ARLEN STREET</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Martha Lea MCGLADE</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>OCTOBER 31 1967</b>  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>CAUC.</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>26 Sept 1926</b>  |
| 9. AGE (In years last birthday) yrs<br><b>41</b>  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>  | 11. BIRTHPLACE (County & State or foreign country)<br><b>ORLANDO, FLORIDA</b>                        |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 13. FATHER'S NAME<br><b>RUPERT WILLIS</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>ALICE VEAZY</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |
| 16. SOCIAL SECURITY NO  |   | 17. INFORMANT (HUSBAND)<br><b>LAWRENCE MCGLADE, SAME AS #2</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory and Cardiac Failure</b><br>DUE TO<br>(b) <b>Carcinomatosis</b><br>DUE TO<br>(c) <b>Adenocarcinoma of Stomach</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>OCT 2, 1967</b> , to <b>OCT 31, 1967</b> , that (I) (we) last saw the deceased alive on <b>31 OCTOBER 1967</b> , and that death occurred on <b>OCT 31, 1967</b> at <b>1:50 AM</b> , from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><i>Charles S. Crummy</i> MD   |   | 22b. DATE SIGNED<br><b>OCT 31, 67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles S. CRUMMY, M.D.</b>  |   | 22d. ADDRESS<br><b>NAVAL HOSPITAL, BETHESDA, MD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>11/1/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL CEM.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>ARLINGTON, VIRGINIA</b>                          |
| 24. FUNERAL DIRECTOR<br><i>John H. Brown</i><br><b>ARLINGTON FUNERAL HOME</b>   |   | 25a. REC'D BY REGISTRAR<br><b>NOV 2 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |



## CERTIFICATE OF DEATH

1-1156

14151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                  |   |   |   |   |  |  |
|--|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>3 hours</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ashton</b>   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Montgomery General Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>18820 New Hampshire Ave.</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Arthur</b> Last <b>McGrath</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>10</b> Year <b>1967</b>   |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 5, 1919</b> |   | 9. AGE (In years last birthday) <b>47</b> yrs | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>19</b> Hours <b>67</b> Min                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Lawyer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lawyer</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Minnesota</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Thomas McGrath</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Lucy Kelly</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW II</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>436-10-1789</b>   |   | 17. INFORMANT<br><b>Medical Records</b>   |   | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>4301</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO (b) <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Coronary Artery Disease</b><br>3 hrs.<br>months |                                  |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic Pancreatitis</b>   |                                  |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)  |   |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour 'o m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 <b>Oct 10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10/10</b> 19 <b>67</b> , and that death occurred at <b>6:55 AM</b> , from causes and on the date stated above  |                                  |   |   |   |   |  |  |
| 22a. SIGNATURE<br><b>Richard A. Yates, M.D.</b>  |                                  |   |   | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>             |   | 22b. DATE SIGNED<br><b>10/10/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Richard A. Yates, M.D.</b>   |                                  |   |   | 22d. ADDRESS<br><b>Old Baltimore Road, Olney, Md.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>10-13-67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Silver Spring, Maryland</b>                |  |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. DUMPHREY, Bethesda, Maryland</b>  |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 16 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |



19  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |                               |  |                                 |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>            |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lexington</i>  |                                 |
| c. LENGTH OF STAY IN 1b <i>35 days</i>  |                               | 15-1   |                                 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>  |                               | d. STREET ADDRESS <i>3703 Calvert Place</i>  |                                 |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                 |
| 3. NAME OF DECEASED<br>(Type or print) <i>William Thomas McKenna</i>  |                               | 4. DATE OF DEATH<br>Month <i>October</i> Day <i>19</i> Year <i>1967</i>  |                                 |
| 5. SEX <i>male</i>  | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3/21/04</i> |
| 9. AGE (In years lost birthday) <i>63</i> yrs   |                               | IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired (Attorney)</i>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>Veterans' Administration - Pennsylvania</i>   |                                 |
| 11. BIRTHPLACE (County & State or foreign country) <i>Pennsylvania</i>  |                               | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |                                 |
| 13. FATHER'S NAME <i>William James McKenna</i>  |                               | 14. MOTHER'S MAIDEN NAME <i>Mary Enright</i>   |                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes 1942-1945</i>  |                               | 16. SOCIAL SECURITY NO <i>577-03-6200</i>  |                                 |
| 17. INFORMANT <i>Mary McKenna - (sister)</i>  |                               | Address <i>3703 Calvert Place</i>  |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary edema</i><br>DUE TO <i>ca larynx</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i><br>(c) <i></i> |                               |  |                                 |
| INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i><br><i>3 yrs</i>  |                               |  |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>   |                               |  |                                 |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)  |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o m p.m. <i>19</i>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1/5/67</i> , 19 <i>67</i> , to <i>10/19</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>10/19</i> 1967, and that death occurred at <i>8:45 PM</i> , from causes and on the date stated above.                       |                               |  |                                 |
| 22a. SIGNATURE <i>Patrick C. Jameson</i> M.D.   |                               | 22b. DATE SIGNED <i>10/20/67</i>   |                                 |
| 22c. PHYSICIAN'S NAME (Type) <i>Patrick C. Jameson</i>  |                               | 22d. ADDRESS <i>11718 Ga Ave Silver Spring Md</i>  |                                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                               | 23b. DATE THEREOF <i>10-24-67</i>  |                                 |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>   |                               | 23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Md.</i>  |                                 |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>  |                               | 25a. REC'D BY REGISTRAR <i>DATE OCT 25 1967</i>  |                                 |
|   |                               | 25b. REGISTRAR'S SIGNATURE <i>Richard J. Judge</i>   |                                 |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |  |  |  |
| Item #2a,c & d File #G-11-1372 ph   |  |  |  |   |  |   |  |   |  |  |  |
| 14153 CERTIFICATE OF DEATH 14153  |  |  |  |   |  |   |  |   |  |  |  |
| 1 PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  |  |  |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Va.</u> b. COUNTY <u>✓</u>     |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>KENSINGTON</u>   |  |  |  | c. LENGTH OF STAY IN <u>Mo. 8 d. 45</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fort Belvoir</u>                           |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>KENSINGTON GARDENS SANITARIUM</u>  |  |  |  |   |  | d. STREET ADDRESS<br><u>1718 Kimbro Loop C-1</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>BRIGETTE F McLEOD</u>  |  |  |  |   |  | 4. DATE OF DEATH <u>Oct 29 1967</u>   |  |   |  |  |  |
| 5 SEX <u>FEMALE</u>   |  | 6 COLOR OR RACE <u>COLORED</u>         |  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                        |  | 8. DATE OF BIRTH <u>DEC 4 1947</u>  |  | 9 AGE (In years last birthday) <u>19</u>    |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Germany</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>Germany</u>   |  |
| 13 FATHER'S NAME<br><u>Fritz Kock</u>   |  |  |  |   |  | 14 MOTHER'S MAIDEN NAME<br><u>Henni Reubert</u>   |  |   |  |  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |  |  |  | 16 SOCIAL SECURITY NO   |  | 17. INFORMANT<br><u>Sgt. Charles McLeod</u> Address   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia - terminal</u><br>DUE TO <u>diffuse cerebral infarction</u><br>stating the underlying cause last (b) <u>asoxia - cardiac arrest</u><br>(c) <u>asoxia - cardiac arrest</u> |  |  |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>?</u><br><u>?</u>              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)   |  |  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)                   |  |   |  |   |  |  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>   |  |  |  | 20d INJURY OCCURRED<br>Where <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f (City or town) (County) (State)         |  |  |  |
| 21 I certify that (I) (this hospital) attended the deceased from <u>Sept 21, 1967</u> , to <u>Oct 29, 1967</u> , that (I) (we) lost <u>the deceased</u> on <u>10/27 1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date, stated above.   |  |  |  |   |  |   |  |   |  |  |  |
| 22a SIGNATURE<br><u>[Signature]</u>   |  |  |  |   |  | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  | 22b DATE SIGNED<br><u>10/29/67</u>          |  |  |  |
| 22c PHYSICIAN'S NAME (Type)<br><u>W F Kreuzburg</u>   |  |  |  |   |  | 22d ADDRESS<br><u>7852 16th Ave NW Wash DC</u>  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b DATE THEREOF<br><u>Nov 3, 1967</u> |  | 23c NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>  |  | 23d LOCATION (City or Town) (County) (State)<br><u>Fort Meyer, Virginia</u>   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br><u>Frozier Funeral Home, Inc. Ave. NW</u>  |  |  |  |   |  | ADDRESS<br><u>1384 R.2.</u>   |  | 25a REC'D BY REGISTRAR<br><u>Nov 6 1967</u> |  | 25b REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                      |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

| <div> <div>14153</div> <div>909pm</div> <div>14153</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div>14153</div>   |  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>DOM</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>  |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>   |  |  |  |  |  | d. STREET ADDRESS <u>9320 Blue Road</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>Paige T. Medairy</u>  |  |  |  |  |  | 4. DATE OF DEATH <u>Oct 17 1967</u>   |  | Month <u>17</u> Day <u>19</u> Year <u>67</u>    |  |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u>              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | DATE OF BIRTH <u>July 6 1922</u>  |  | 9. AGE (In years last birthday) <u>45</u> yrs   |  | 10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min <u></u>                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharm Foreman</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u></u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |
| 13. FATHER'S NAME <u>Edmund Medairy</u>  |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Waisy Perrell</u>   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>U.S. Army</u>   |  |  |  | 16. SOCIAL SECURITY NO <u>214-16-1275</u>  |  | 17. INFORMANT <u>Jeannette Medairy</u> Address <u>same as above</u>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> (b) <u>Acute</u> (c) <u>Sudden</u>  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |  |  |  |  |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>   |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>  |  | 20f. (City or town) (County) (State) <u></u>    |  |  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D.  |  |  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |  |  |
| EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>   |  |  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |  |  |
|  |  |  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/17/67  |  |   |  |  |  |
|  |  |  |  |  |  | Address (Street, city, town, or county) <u></u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>Oct. 21, 1967</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>   |  | 23d. LOCATION (City or Town) (County) (State) <u>Damascus, Md.</u>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <u></u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |  |  |  |
|  |  |  |  |  |  | DATE <u>OCT 23 1967</u>   |  |   |  |  |  |



## CERTIFICATE OF DEATH

14160

14155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda Rural</b>  |   | c. LENGTH OF STAY IN lb<br><b>2 Days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>  |   | d. STREET ADDRESS<br><b>10500 Rockville Pike</b>  |   |
| 3 NAME OF DECEASED (Type or print)<br><b>Kenmore E. MERRIAM</b>  |   | 4 DATE OF DEATH<br>Month <b>Oct</b> Day <b>18</b> Year <b>1967</b>  |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>Cauc</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb 1, 1903</b>  |
| 9 AGE (In years last birthday)<br><b>64 yrs</b>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><b>U. S. NAVY</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Armed Forces</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Robert Merriam</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>FLORENCE MILLER</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes W.W.II</b>  |   | 16. SOCIAL SECURITY NO<br><b>561 54 9596</b>  |   |
| 17. INFORMANT<br><b>Mary Merriam</b>   |   | Address<br><b>10500 Rockville Pike, Rockville, Md.</b>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>16 Oct.</b> , 19 <b>67</b> , to <b>18 Oct.</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>18 Oct.</b> 19 <b>67</b> , and that death occurred at <b>8:42 PM</b> from causes and on the date stated above. |   |   |   |
| 22a. SIGNATURE<br><b>Robert J. Kinney</b>  |   | 22b. DATE SIGNED<br><b>20 October 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert J. Kinney, M. D.</b>   |   | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>10/23/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington Va.</b>                             |
| 24. FUNERAL DIRECTOR<br><b>Jos. Gawler &amp; Sons</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 29 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |   |  |   |  |  |   |
|---|--|------------------------------|--|---|--|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |   |  |   |  |  |   |
| 14155   |  |                              |  |   | 14161  |   |  |  |   |
| CERTIFICATE OF DEATH  |  |                              |  |   |  |   |  |  |   |
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>   |  |                              |  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>VIRGINIA</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FALLS CHURCH</b><br>d. STREET ADDRESS <b>6166 LEESBURG PIKE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>JACOB J. MICHAELSON</b>  |  |                              |  |   | 4 DATE OF DEATH<br>Month <b>October</b> Day <b>11</b> Year <b>1967</b>   |   |  |  |   |
| 5 SEX <b>MALE</b>   |  | 6 COLOR OR RACE <b>WHITE</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH <b>NOV. 27, 1927</b>                                      |  | 9. AGE (In years last birthday) <b>39</b> yrs<br>IF UNDER 1 YEAR: Months <b>39</b> Days <b>39</b> Hours <b>39</b> Min. |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRUG STORE CLERK</b>  |  |                              |  | 10b KIND OF BUSINESS OR INDUSTRY  |  | 11 BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>        |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>SOL MICHAELSON</b>   |  |                              |  |   | 14. MOTHER'S MAIDEN NAME <b>SONIA BLUMENTHAL</b>   |   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) <b>YES</b> <b>KOREA</b> (If yes give year or dates of service)  |  |                              |  | 16. SOCIAL SECURITY NO <b>234 32 6227</b>   |  | 17. INFORMANT <b>WIFE</b> Address <b>MRS. MARSHIA MICHAELSON-AS ABOVE</b> |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO <b>4201</b><br>(b) <b>Atherosclerotic Coronary Artery Disease</b><br>DUE TO <b>4201</b><br>(c) <b>lost.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                              |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>  |  |                              |  |   |  |   |  |  | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  |  |                              |  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)     |  | 20f (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 1966, to <b>Oct 10</b> , 1967, that (I)(we) last saw the deceased alive on <b>Oct 10</b> , 1967, and that death occurred at <b>2:00</b> M, from causes and on the date stated above.  |  |                              |  |   |  |   |  |  |   |
| 22a SIGNATURE <b>Richard H. Edenbaum</b> M.D.   |  |                              |  |   | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>  |   |  | 22b. DATE SIGNED <b>10/11/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Richard H. Edenbaum MD</b>  |  |                              |  |   | 22d ADDRESS <b>4700 Brookly Blvd. Ch. Ch. Md.</b>  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b DATE THEREOF             |  | 23c NAME OF CEMETERY OR CREMATORY   |  |   | 23d LOCATION (City or Town) (County) (State) |  |   |
| <b>BURIAL</b>   |  | <b>10-13-67</b>              |  | <b>NATIONAL CAPITAL HEBREW CEM.</b>   |  |   | <b>WASHINGTON, DC</b>                        |  |   |
| 24 FUNERAL DIRECTOR <b>BERNARD DANZANSKY &amp; SONS</b>   |  |                              |  |   | ADDRESS <b>WASHINGTON DC</b>   |   | 25a. RECD BY REGISTRAR <b>OCT 16 1967</b>    |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>  |





14157

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                               |  |                                 |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>            |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>   |                                 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>   |                               | d. STREET ADDRESS <i>5415 Glenwood Road</i>  |                                 |
| 3. NAME OF DECEASED<br>(Type or print) <i>Charles - Russell-Miller</i>   |                               | 4. DATE OF DEATH <i>October 19 1967</i>  |                                 |
| 5. SEX <i>male</i>   | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/22/04</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>  |                               | 11. BIRTHPLACE (County & State, or foreign country) <i>Detroit - Michigan</i>  |                                 |
| 10b. KIND OF BUSINESS OR INDUSTRY <i>Charles S. Miller Co.</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |                                 |
| 13. FATHER'S NAME <i>Harry Albert Miller</i>   |                               | 14. MOTHER'S MAIDEN NAME <i>Leona E. Miller</i>  |                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>  |                               | 16. SOCIAL SECURITY NO. <i>5415 Glenwood</i>   |                                 |
| 17. INFORMANT <i>Mrs. C. Miller</i>  |                               | Address <i>5415 Glenwood</i>   |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cachexia</i><br>DUE TO <i>Metastatic reticulum cell lymphoma</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>lymphoma</i><br>(c) |                               | INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i><br><i>10 months</i>  |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <i>none</i>   |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <i>19</i>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Feb 21, 1967</i> to <i>Oct 17, 1967</i> , that (I) (we) last saw the deceased alive on <i>Oct 17, 1967</i> , and that death occurred at <i>9:22 PM</i> , from causes and on the date stated above.  |                               |  |                                 |
| 22a. SIGNATURE <i>Allen J. O'Neill</i> M.D.  |                               | 22b. DATE SIGNED <i>Oct 19, 1967</i>   |                                 |
| 22c. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill MD</i>  |                               | 22d. ADDRESS <i>8601 Old George Town Rd</i>  |                                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                               | 23b. DATE THEREOF <i>10-24-67</i>  |                                 |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>  |                               | 23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>   |                                 |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>   |                               | 25a. REC'D BY REGISTRAR <i>OCT 25 1967</i>   |                                 |
|  |                               | 25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>   |                                 |



14158

CERTIFICATE OF DEATH

14164

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY MEDICAL EXAMINER  
MEDICAL CERTIFICATE

|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a COUNTY <u>MONTGOMERY</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <u>MD</u> b COUNTY <u>MTGOMY</u>                         |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>   |   | c LENGTH OF STAY IN 1b <u>DOA</u>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>  |   | e STREET ADDRESS <u>8508 16<sup>th</sup> ST.</u>  |   |
| 3 NAME OF DECEASED (Type or print) <u>JOHN D MORAN</u>   |   | 4 DATE OF DEATH Month <u>OCT</u> Day <u>8</u> Year <u>1967</u>  |   |
| 5 SEX <u>M</u>   | 6 COLOR OR RACE <u>W</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>JUNE 19-80</u> 9 AGE (In years last birthday) <u>87</u> yrs                |
| Do. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER ST. MARY CITY of N.Y.</u>   |   | 10b KIND OF BUSINESS OR INDUSTRY <u>IREZ AND</u>  |   |
| 11. BIRTHPLACE (County & State or foreign country) <u>IREZ AND</u>   |   | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Daniel Moran</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Condemun</u>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>   |   | 16 SOCIAL SECURITY NO <u>095 38 0626</u>  |   |
| 17. INFORMANT <u>Hosp Records</u>  |   | Address   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arterio-sclerotic Heart Disease</u><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE LEFT HUMERUS 9-28-67</u>  |   |   | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-28, 1967</u> to <u>OCT 8<sup>th</sup>, 1967</u> , that (I) (we) lost saw the deceased alive on <u>OCT 8, 1967</u> , and that death occurred at <u>9:50 AM</u> , from causes and on the date stated above.   |   |   |   |
| 22a SIGNATURE <u>Robert Kramer</u> M.D.  |   | 22b DATE SIGNED <u>10-8-67</u>  |   |
| 22c PHYSICIAN'S NAME (Type) <u>Robert Kramer</u>   |   | 22d ADDRESS <u>8484 16<sup>th</sup> ST. SS. MD</u>  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b DATE THEREOF <u>Oct. 11, 1967</u>   | 23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>   | 23d LOCATION (City or Town) (County) (State) <u>Hawthorne, N.Y.</u>                           |
| 24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>434-GA Ave Silver Spring, Md</u>   |   | 25a REC'D BY REGISTRAR DATE <u>OCT 10 1967</u>  | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #2c & d fill in #1-93 10/23/67 ph

CERTIFICATE OF DEATH

1-1163

|  |  |   |   |
|--|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u> Kensington   |   |
| c. LENGTH OF STAY IN 1b <u>2+ yrs.</u>   |  | d. STREET ADDRESS <u>119001 Oakview Drive</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Althea Woodland Nsg. Home 1000 Oakview Dr.</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>Florence M. Morrow</u>  |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>14</u> Year <u>1967</u>  |   |
| 5. SEX <u>Fe</u>   | 6. COLOR OR RACE <u>Cauc.</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-30-1877</u>                                   |
| 9. AGE (In years last birthday) <u>90</u> yrs  |  | IF UNDER 1 YEAR<br>Months <u>14</u> Days <u>14</u> Hours <u>67</u> Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>  |   |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Monmouth, Illinois</u>   |  | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Jacob Morningstar</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Catherine Strahorn</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u><br>(Yes, no, or unknown) (If yes give war or dates of service)   |  | 16 SOCIAL SECURITY NO <u>-</u>  |   |
| 17 INFORMANT <u>Beverly Heasley</u>  |  | Address <u>811 Houston Ave TR, PK.</u>  |   |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Carcinoma, Uterine</u><br>DUE TO<br>(b) <u>174 X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)  | 20f (City or town) (County) (State)                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 11, 1965</u> to <u>Oct 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>10-13</u> 19 <u>67</u> , and that death occurred at <u>2:28 PM</u> , from causes and on the date stated above.                            |  |   |   |
| 22a. SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.   |  | 22b. DATE SIGNED <u>10-14-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>  |  | 22d. ADDRESS <u>217 UNIV. BLVD E. SIL SP MD</u>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>  | 23b DATE THEREOF <u>10/16/67</u>   | 23c NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>   | 23d LOCATION (City or Town) (County) (State) <u>Washington D.C.</u> |
| 24 FUNERAL DIRECTOR <u>J. Wm. Lees Sons, 300 4th St. NE, Wash., DC</u>   |  | 25a REC'D BY REGISTRAR <u>OCT 17 1967</u>   |   |
|  |  | 25b REGISTRAR'S SIGNATURE <u>J. Wm. Lees</u>  |   |



CERTIFICATE OF DEATH

14165

1 PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b 22 days  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland  
2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)  
a. STATE Maryland b. COUNTY Washington  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown  
d. STREET ADDRESS Route #3  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒  
3 NAME OF DECEASED (Type or print) First Middle Last Donald Bennett Millendore  
4 DATE OF DEATH Month Day Year October 15 1967  
5 SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH 27 October 1898 9 AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant 10b KIND OF BUSINESS OR INDUSTRY Manufacturing 11. BIRTHPLACE (County & State, or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? USA  
13 FATHER'S NAME Edward C. Mullendore 14 MOTHER'S MAIDEN NAME Laura B. Lewis  
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16 SOC. SEC. NO. 214-09-8122 17 INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Pulmonary Embolus  
DUE TO (b) Stem cell lymphoma  
DUE TO (c) Chronic lymphocytic leukemia  
INTERVAL BETWEEN ONSET AND DEATH 3 weeks  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 years  
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)  
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d INJURY OCCURRED While ☐ Not While ☐ at work at work  
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f (City or town) (County) (State)  
21. I certify that ☒ (this hospital) attended the deceased from Sept. 23, 1967, to Oct. 15, 1967, that ☒ (we) last saw the deceased alive on Oct. 15, 1967, and that death occurred at 7:40 M. from causes and on the date stated above.  
22a SIGNATURE Paul P. Carbone P.M. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED 16 Oct. 1967  
22c. PHYSICIAN'S NAME (Type) Paul P. Carbone, M.D. 22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.  
23a BURIAL CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10-18-67 23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City or town) (County) (State) Hagerstown, Md.  
24 FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. 25a REC'D BY REGISTRAR OCT 20 1967 25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





CERTIFICATE OF DEATH

14161

14166

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>27 days</u>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY <u>Westmoreland</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensale</u> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |   | d. STREET ADDRESS <u>Rt 1 Box 31</u><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>George W. Mullins</u><br>First Middle Last  |   | 4. DATE OF DEATH <u>10 21 1967</u><br>Month Day Year   |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>4-23-96</u><br>9. AGE (In years last birthday) <u>71</u> yrs               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>George Henry</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Lois Anne Lendrum</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW I Army</u>   |   | 16. SOCIAL SECURITY NO. <u>449 03 9530</u>   |  |
| 17. INFORMANT <u>Mary Mullins</u>  |   | Address <u>same as above</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Right hemiplegia with global aphasia</u><br>DUE TO (b) <u>Cerebrovascular thrombosis</u><br>DUE TO (c) <u>Cerebrovascular sclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>29 days</u>  |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>am</u> <u>19</u> p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25, 1967</u> to <u>Oct 21, 1967</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>Oct 21, 1967</u> , and that death occurred at <u>10:35 P.M.</u> from causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE <u>Stewart Clapp M.D.</u> M.D.  |   | 22b. DATE SIGNED <u>Oct 21 1967</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>   |   | 22d. ADDRESS <u>4740 Chevy Chase Dr</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Oct. 25-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>                        |
| 24. FUNERAL DIRECTOR <u>Ammons Bros</u>  |   | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   | DATE <u>OCT 24 1967</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #4 Film #339L 10/30/67 ph

CERTIFICATE OF DEATH

1162

14167

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>   |  | d. STREET ADDRESS <u>510 University Blvd E.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Margaret McIntosh Myers</u>  |  | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>19</u> Year <u>1967</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-26-10</u><br>AGE (In years last birthday) <u>56</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.C.</u>   |   |
| 11. FATHER'S NAME <u>Joseph Holland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>   |   |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Fannie McIntosh Myers</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u>  |  | 16. SOCIAL SECURITY NO <u>yes</u>   |   |
| 17. INFORMANT <u>James H. Myers</u>  |  | 18. ADDRESS <u>510 University Blvd E. Silver Spring, Md.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Malnutrition, inanition</u><br>DUE TO (b) <u>Carcinoma of colon w metastases</u><br>DUE TO (c) <u>4 yrs.</u>  |  | INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>Oct. 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 18</u> , 19 <u>67</u> , and that death occurred at <u>9:20 A.M.</u> from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE <u>Mar. Schuel</u>  |  | 22b. DATE SIGNED <u>10/19/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Marvin Schueler</u>  |  | 22d. ADDRESS <u>911 Silver Spring Ave.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Oct. 23, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Hartsville, Maryland</u>         |
| 24. FUNERAL DIRECTOR <u>Carter C. Gantner</u>  |  | 25a. REC'D BY REGISTRAR <u>John S. Pambour, Inc. 3434 Ga. Ave. S.E. Md.</u>   |   |
| 25b. REGISTRAR'S SIGNATURE <u>John S. Pambour, Inc.</u>  |  | DATE <u>OCT 26 1967</u>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon properly. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |
|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |
| 14169  |  | 14169  |   |
| CERTIFICATE OF DEATH   |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>MONT.</b>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |  | c. LENGTH OF STAY IN 1b<br><b>15 1</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HOLY CROSS HOSPITAL</b>  |  | d. STREET ADDRESS<br><b>12 S. FREDERICK AVE. #106</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>HAZEL R. NORRIS</b>  |  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>8</b> Year <b>19 67</b>   |   |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-17-08</b> 59 yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MASS</b>   |  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Marie &amp; Orlene Smith, M.D.</b>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>adrenal insufficiency</b><br>DUE TO (b) <b>transfusion + acute infection</b><br>DUE TO (c) <b>disseminated collagenosis</b>                 |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>1 wk</b><br><b>1 yr.</b>                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Rheumatoid arthritis</b>   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/1/67</b> , to <b>10/8/67</b> , that (I) (we) lost saw the deceased alive on <b>10/8/1967</b> , and that death occurred on <b>10/8/67</b> at <b>7:30 PM</b> , from causes, and on the date stated above. |  |  |   |
| 22a. SIGNATURE<br><b>[Signature]</b>   |  | 22b. DATE SIGNED<br><b>10/9/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>STEPHEN M. JONES, M.D.</b>  |  | 22d. ADDRESS<br><b>809 VINTAGE RD. ROCKVILLE, MD 20850</b>   |   |
| 23a. BURIAL, CREMATION, REMOVA. (Specify)  | 23b. DATE THEREOF<br><b>Oct 10/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Oak</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Gaithersburg, Md.</b>                         |
| 24. FUNERAL DIRECTOR<br><b>Ernest C. Gartner</b>   |  | 25a. REC'D BY REGISTRAR<br><b>[Signature]</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  | DATE<br><b>OCT 13 1967</b>   |   |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14168

|   |   |  |                                      |
|---|---|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |   | c. LENGTH OF STAY IN 1b <u>D.O.A.</u>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp'tal, give street address) <u>Wash. San. &amp; Hosp.</u>  |   | d. STREET ADDRESS <u>9101 Providence ave</u>   |                                      |
| 3. NAME OF DECEASED (Type or print) <u>John Charles Norman</u>  |   | 4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1967</u>  |                                      |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-8-20</u>       |
| 9. AGE (In years last birthday) <u>47</u> yrs   |   | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Supplies Self employed</u>   |   | 12. BIRTHPLACE (State or foreign country) <u>Penna.</u>  |                                      |
| 13. FATHER'S NAME <u>Charles John Norman</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Genevieve Durang</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give year or dates of serv) <u>No xxx years</u>  |   | 16. SOCIAL SECURITY NO. <u>579-40-6325</u>   |                                      |
| 17. INFORMANT <u>Charles J. Norman</u>  |   | <u>9110 Providence Ave Silver Spring, Md.</u>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><u>434.3</u> IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency accompanied</u><br>DUE TO (b) <u>by acute laryngeal edema;</u><br>DUE TO (c) <u>Chronic pericarditis</u>  |   | INTERVAL BETWEEN ONSET AND DEATH   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Achondroplastic dwarf with multiple congenital anomalies.</u>  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. p.m. <u>19</u>   | 20d. WHERE OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |                                      |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
| 22. DATE SIGNED <u>10/29/1967</u>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |   | 23b. DATE THEREOF <u>Nov. 1, 1967</u>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>   |   | 23d. LOCATION (City or town) (County) (State) <u>Arlington, Virginia</u>   |                                      |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>8434 Ardmore Avenue</u><br><u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u>  |   | 25a. REC'D BY REGISTRAR <u>Charles J. George</u>   |                                      |
| DATE <u>NOV 1 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE   |                                      |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
25M 11-67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14165

14170

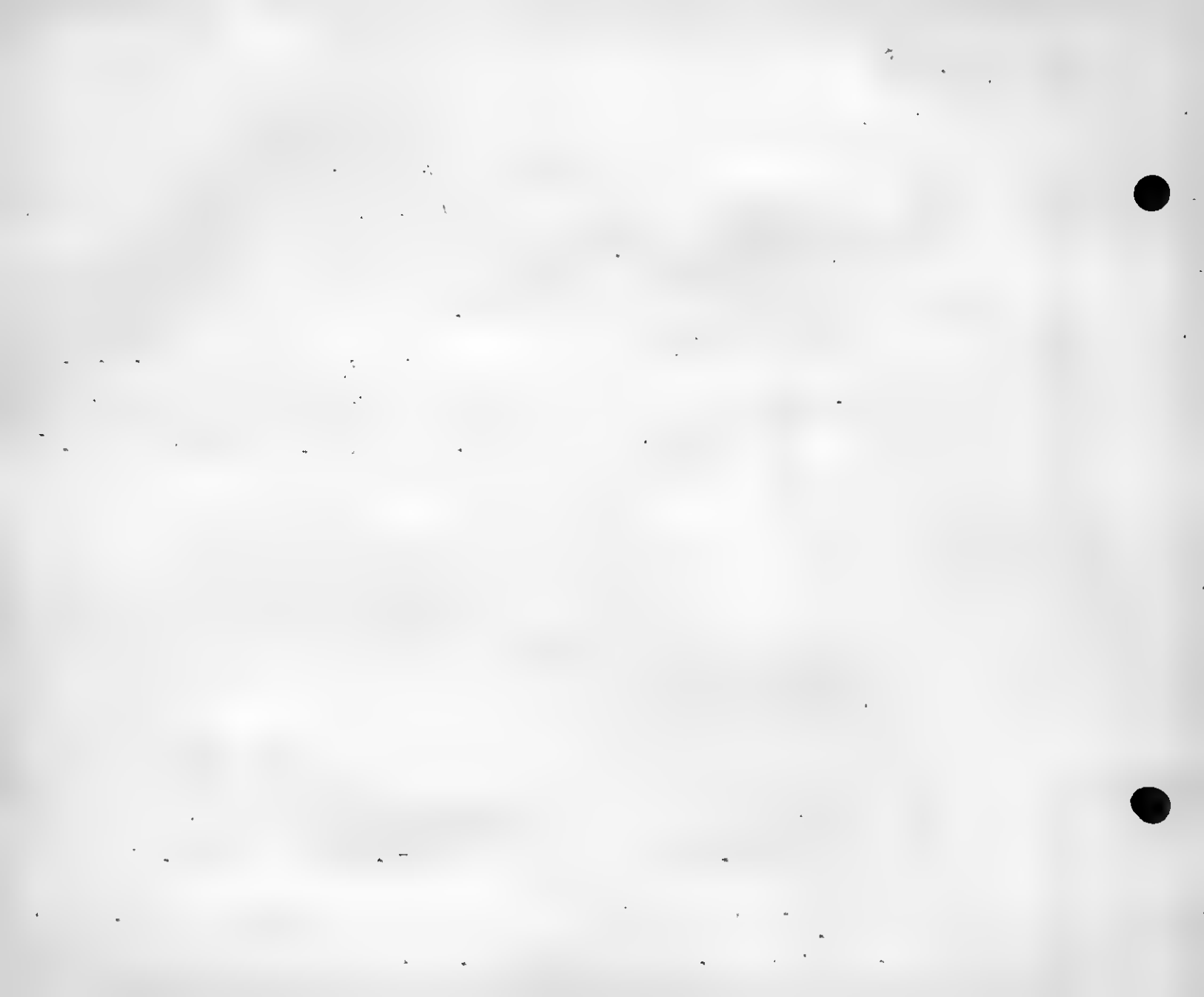
|   |                                  |  |  |   |   |   |  |
|---|----------------------------------|--|--|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  |  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Res. before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BETHESDA</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>24 days</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BETHESDA</u>                                     |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban HOSPITAL</u>  |                                  |  |  | d. STREET ADDRESS <del>XXXXXXXX</del><br><u>7608 LEESBURG DRIVE</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print)<br>First <u>JACOB</u> Middle <u></u> Last <u>OBICAS</u>  |                                  |  |  | 4 DATE OF DEATH<br>Month <u>Oct</u> Day <u>30</u> Year <u>1967</u>  |   |   |  |
| 5 SEX<br><u>MALE</u>  | 6 COLOR OR RACE<br><u>W HITE</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH<br><u>JAN. 1894</u> <del>XXXXXXXXXX</del> |   | 9 AGE (In years last birthday)<br><u>73</u> <del>XXXXXX</del> yrs |   | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>A TAILOR</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>SHOP</u>   |  | 11 BIRTHPLACE (County & State, or foreign country)<br><u>LITHUANIA</u>  |   | 12 (IT ZEN OF WHAT COUNTRY?)<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><del>XXXXXXXXXX</del> <u>NEVER OBICAS</u>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><del>XXXXXXXXXX</del> <u>RIFKA ?</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u></u>   |  | 17. INFORMANT<br><u>MRS. FREDA OBICAS,</u> Address <u>7608 LEESBURG DR, BETHESDA, MARYLAND</u>  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u><br><u>5010</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Post Necrotic Cirrhosis</u> (b) DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u> |                                  |  |  |   |   |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |   |   | 19 WAS A TOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B)   |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1966</u> to <u>Oct 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>29 Oct 1967</u> , and that death occurred at <u>12:02 AM</u> , from causes on and on the date stated above.   |                                  |  |  |   |   |   |  |
| 22a. SIGNATURE<br><u>Stanley M. Bialek</u>  |                                  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>    |   | 22b. DATE SIGNED<br><u>Oct. 30, 1967</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>DR. STANLEY M. BIALEK</u>  |                                  |  |  | 22d. ADDRESS<br><u>8218 Wisc. Ave. Bethesda, Md.</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 23b. DATE THEREOF<br><u>10-30-1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>HAR ZION TIFERETH ISRAEL</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTIMORE, MARYLAND</u>                       |  |
| 24 FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN ROAD</u>   |                                  |  |  | 25a. REC'D BY REGISTRAR<br><u>DATE NOV 6 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |  |   |  |   |  |  |  |  |  |
|--|--|-------------------------------|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |                               |  |   |  |   |  |  |  |  |  |
| 14165  |  |                               |  |   |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |                               |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |                               |  | c. LENGTH OF STAY IN 1b <u>27 years</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |  |  |  | d. STREET ADDRESS <u>10219 Ridgemoor Drive</u>             |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10219 Ridgemoor Drive</u>  |  |                               |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>FLORENCE Brady O'BRIEN</u>  |  |                               |  |   |  | 4. DATE OF DEATH <u>October 29 19 67</u>  |  |  |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Nov. 17, 1909</u>   |  | 9. AGE (In years last birthday) <u>57</u> yrs.                                       |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Frankfort, New York</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>               |  |
| 13. FATHER'S NAME <u>Frank E. Brady</u>  |  |                               |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Doyle</u>   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |                               |  | 16. SOCIAL SECURITY NO. <u>None</u>   |  | 17. INFORMANT <u>John B. O'Brien, Jr.</u>   |  | Address <u>10219 Ridgemoor Dr. Silver Spring, Md.</u>                                |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency - Progressive</u><br>518X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Left Ventricular failure -</u><br>OUE TO (c) <u>Granulomatous Colitis -</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>for years</u><br><u>1 wk</u><br><u>4 years</u> |  |                               |  |   |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                               |  |   |  |   |  |  |  |  |  |
| MEDICAL CERTIFICATION  |  |                               |  |   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>to Present</u> , 19 <u>that (I) (we) last saw the deceased alive on Oct 13 1967</u> , and that death occurred at <u>10219 Ridgemoor Dr.</u> , from the causes and on the date stated above.  |  |                               |  |   |  |   |  |  |  |  |  |
| 22a. SIGNATURE <u>John D. Cunnnett, M.D.</u>   |  |                               |  |   |  | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  | 22b. DATE SIGNED <u>10/30/67</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>John D. Cunnnett</u>   |  |                               |  |   |  | 22d. ADDRESS <u>1746-K Street NW Wash. DC</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                               |  | 23b. DATE THEREOF <u>Oct. 31, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>               |  |  |  |
| 24. FUNERAL DIRECTOR <u>C. Glen Carter</u>   |  |                               |  |   |  | ADDRESS <u>8434 Georgia Avenue</u>  |  | 25a. REC'D BY REGISTRAR <u>NOV 1 1967</u> REGISTRAR'S SIGNATURE <u>Charles Judge</u> |  |  |  |
| Warner E. Pumphrey, Inc. <u>Silver Spring, Md.</u>   |  |                               |  |   |  |   |  |  |  |  |  |



3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14167

14172

|   |                                  |   |  |   |  |   |  |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>M.D.</u> b. COUNTY <u>Montgomery</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  | c. LENGTH OF STAY IN 1b<br>--   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda Silver Spring</u>                         |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Bethesda Silver Spring's Nursing Home</u>  |                                  |   |  | d. STREET ADDRESS<br><u>104 E Lenox St Ch/ch</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Ugatha T. O'Donoghue</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>24</u> Year <u>1967</u>  |  |   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12/12/74</u>                                    |   | 9. AGE (In years last birthday)<br><u>92</u> yrs |   | 10. IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>24</u> Hours <u>19</u> Min <u>67</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>--   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housewife</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>VA.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>John Mahoney</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Bridget Larkin</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>--   |                                  | 16. SOCIAL SECURITY NO<br>--  |  | 17. INFORMANT<br><u>Mrs. Stephen W. Nealon, 104 E. Lenox St. Chevy Chase, Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>Generalized Arteriosclerosis</u> |                                  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hrs</u><br><u>10 yrs</u><br><u>unknown</u>    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)   |                                  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)             |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1957, to <u>Oct</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/24</u> , 1967, and that death occurred at <u>6:05 AM</u> , from causes and on the date stated above.         |                                  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><u>James J. Foster</u>  |                                  |   |  | 22b. DATE SIGNED<br><u>10/24/67</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. James J. Foster</u>  |  |
| 22d. ADDRESS<br><u>1746 "K" Street, N.W. Wash. D.C.</u>   |                                  |   |  | 22e. MED. PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>10-26-1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D.C.</u>                          |  |
| 24. FUNERAL DIRECTOR<br><u>James J. Foster</u>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><u>OCT 26 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Jones</u>   |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14168

14173

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>  |   |
| c. LENGTH OF STAY IN 1b <u>DOA</u>  |   | d. STREET ADDRESS <u>1801 Belmont St.</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3 NAME OF DECEASED (Type or print) <u>JOHN</u> First Middle Last <u>OLLIE</u>   |   | 4 DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1967</u>   |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>C</u>                   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>June 6, 1896</u>          |
| 9. AGE (In years last birthday) <u>71</u> yrs.  |   | 10. IF UNDER 1 YEAR Months Days   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Smith Development</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Ala</u>  |   | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Nash Ollie</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Maria P</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO <u>578073441</u>   |   |
| 17. INFORMANT   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))   |   |   |   |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4301 Coronary Insufficiency -</u>   |   |   |   |
| DUE TO (b) <u>Cardiovascular Disease -</u>  |   |   |   |
| DUE TO (c)  |   |   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE <u>John S. Bell</u> M.D.   |   | 22. DATE SIGNED <u>Oct-23/67</u>  |   |
| EXAMINER'S NAME (Type)  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF <u>10/30/67</u>           | 23c. NAME OF CEMETERY OR CREMATORY <u>Shannon Memorial Park, Landover Md.</u>   | 23d. LOCATION (City or town) (County) (State) |
| 24. FUNERAL DIRECTOR <u>Johnson &amp; Jenkins 4804 Ge Ave P.O. D.C.</u>   | 25a. REC'D BY REG. STRAR <u>Oct 26 1967</u> | 25b. REG. STRAR'S SIGNATURE <u>Charles J. J...</u>  |   |





14168

CERTIFICATE OF DEATH

14174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Med. Examiner  
O'MALLEY

|  |                               |  |                                       |   |  |
|--|-------------------------------|--|---------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                               | c. LENGTH OF STAY IN lb <u>209</u>   |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       | d. STREET ADDRESS <u>1110 Schindler Drive</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>(NMN)</u> Last <u>O'Malley</u>  |                               | 4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1967</u>   |                                       |   |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>Jan. 16, 1913</u> |   | 9. AGE (In years last birthday) <u>54</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Drivers</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Paint Products</u>  |                                       | 11. BIRTHPLACE (County & State or foreign country) <u>Ireland</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                               | 13. FATHER'S NAME <u>Anthony O'Malley</u>  |                                       | 14. MOTHER'S MAIDEN NAME <u>Bridget Hughes</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>   |                               | 16. SOCIAL SECURITY NO. <u>236-18-8703</u>   |                                       | 17. INFORMANT <u>Catherine K. O'Malley</u> Address <u>1110 Schindler Drive Silver Spring, Md.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <u>Coronary Artery Disease</u><br>(c) <u>Arteriosclerosis</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>   |                                       |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)  |                                       |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |                               |  |                                       |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>Oct 18</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Sept 17</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.   |                               |  |                                       |   |  |
| 22a. SIGNATURE <u>R. A. Yates</u>  |                               | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |                                       | 22b. DATE SIGNED <u>10/18/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>R. A. YATES</u>  |                               | 22d. ADDRESS <u>OLNEY, Md</u>  |                                       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>Oct 21, 1967</u>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY <u>Rocklawn Cemetery</u>   |  |
| 23d. LOCATION (City or Town) (County) (State) <u>Rockville Maryland</u>  |                               |  |                                       |   |  |
| 24. FUNERAL DIRECTOR <u>John E. Dunbar, Jr.</u>  |                               | 25a. REC'D BY REGISTRAR <u>John E. Dunbar, Jr.</u>   |                                       | 25b. REGISTRAR'S SIGNATURE <u>John E. Dunbar, Jr.</u>   |  |
| DATE <u>OCT 23 1967</u>  |                               |  |                                       |   |  |



## CERTIFICATE OF DEATH

14175

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ROCKVILLE</b>  |  | c. LENGTH OF STAY IN 1b<br><b>ROCKVILLE</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>624 Blossom Drive</b>  |  | d. STREET ADDRESS<br><b>624 Blossom Drive</b>   |  |
| 3 NAME OF DECEASED<br>(Type or print) <b>JEANNE AGNES OSBAHR</b>  |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>23</b> Year <b>1967</b>   |  |
| 5 SEX<br><b>FEMALE</b>  | 6 COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 6, 1930</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teacher</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9 AGE (In years last birthday)<br><b>37</b> yrs.                               |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Philadell Pa</b>   |  | 12 CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>John Culliton</b>   |  | 14 MOTHER'S MAIDEN NAME<br><b>Helen Zeiss</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16 SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Albert J. Osbahr, Jr.</b>   |  | Address<br><b>Same as Item 2.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HODGKINS DISEASE</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour 'a.m. 19<br>p.m.  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>January 1964</b> to <b>Oct 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 23, 1967</b> and that death occurred at <b>4 P.M.</b> , from causes and on the date stated above.              |  |   |  |
| 22a SIGNATURE<br><b>HERIVAN C. MAGARZINI</b>  |  | 22b DATE SIGNED<br><b>10/23/67</b>  |  |
| 22c PHYSICIAN'S NAME (Type)<br><b>HERIVAN C. MAGARZINI</b>  |  | 22d ADDRESS<br><b>50 W. Edmonston Dr., Rockville</b>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>10-26-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>   | 23d LOCATION (City or Town) (County) (State)<br><b>Silver Spring, Maryland</b> |
| 24 FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 26 1967</b>  | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                              |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14176

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                              |   |                                    |
|--|------------------------------|---|------------------------------------|
| 1 PLACE OF DEATH<br>a COUNTY <u>MONTGOMERY</u> MARYLAND  |                              | 2 USUAL RESIDENCE (Where deceased lived if institution Reside before admission)<br>a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>                   |                                    |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>KENSINGTON</u>   |                              | c LENGTH OF STAY IN TB<br><u>10</u>   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SUBURBAN</u>  |                              | d STREET ADDRESS<br><u>3907 HAMPTON ST</u>  |                                    |
| 3 NAME OF DECEASED (Type or print) <u>George MARSHALL OVERS</u>  |                              | 4 DATE OF DEATH Month <u>OCT</u> Day <u>6</u> Year <u>1967</u>  |                                    |
| 5 SEX <u>MALE</u>  | 6 COLOR OR RACE <u>Negro</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Nov. 6-1904</u> |
| 9 AGE (In years last birthday) <u>62</u> yrs   |                              | IF UNDER 1 YEAR Months Days Hours Min   |                                    |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FOREMAN TRACK</u>   |                              | 10b KIND OF BUSINESS OR INDUSTRY <u>BARNESVILLE, Md.</u>  |                                    |
| 11 BIRTHPLACE (State or foreign country)   |                              | 12 CITIZEN OF WHAT COUNTRY?   |                                    |
| 13 FATHER'S NAME <u>JAMES HENRY</u>  |                              | 14 MOTHER'S MAIDEN NAME <u>Molly Elizabeth JACKSON</u>  |                                    |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                              | 16 SOCIAL SECURITY NO   |                                    |
| 17 INFORMANT <u>Louise OVERS - BARNESVILLE, Md.</u>  |                              | Address   |                                    |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia.</u><br>DUE TO<br>(b) <u>Cardiac Hypertrophy + Dilatation.</u><br>DUE TO<br>(c) <u>4547</u><br>Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost   |                              | INTERVAL BETWEEN ONSET AND DEATH <u>5</u> years   |                                    |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              |   |                                    |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                              | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I. of Item 18.)  |                                    |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |                              | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |
| 20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)  |                              | 20f (City or town) (County) (State)   |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |   |                                    |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D.  |                              | 22. DATE SIGNED <u>10/6/67</u>  |                                    |
| EXAMINER'S NAME (Type)   |                              | Address (Street, city, town, or county)   |                                    |
| 23a BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>   |                              | 23b DATE THEREOF <u>10/10/67</u>  |                                    |
| 23c NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Cemetery</u>   |                              | 23d LOCATION (City or town) (County) (State) <u>CLARKSBURG, Montg. Md.</u>  |                                    |
| 24 FUNERAL DIRECTOR <u>Robert L. Snowden</u>   |                              | 25a REC'D BY REG. STRAR <u>John Charles Judge</u>   |                                    |
| ADDRESS <u>Rockville, Md.</u>  |                              | 25b REG. STRAR'S SIGNATURE  |                                    |



## CERTIFICATE OF DEATH

141777  
Reg. Dist. No.

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                                   | c. LENGTH OF STAY IN 1b <u>25 years</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4515 Highland Ave.</u>   |                                   | d. STREET ADDRESS <u>4515 Highland Ave.</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>SAMUEL</u> Middle <u>R.</u> Last <u>PAINTER</u>  |                                   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>14</u> Year <u>1967</u>  |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 22, 1899</u>   |
| 9. AGE (In years last birthday) <u>68</u> ym.  |                                   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   | IF UNDER 24 HRS<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |                                   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>   |   |
| 13. FATHER'S NAME <u>Edward G. Painter</u>   |                                   | 14. MOTHER'S MAIDEN NAME <u>(Unknown) Morris</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>  </u>  |                                   | 16. SOCIAL SECURITY NO. <u>215-44-8255</u>  |   |
| 17. INFORMANT <u>Wife</u> Address <u>Same as item 2.</u>   |                                   | 17. INFORMANT <u>With Painter</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of bladder</u><br>DUE TO (b) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u>  </u><br>DUE TO (b) <u>  </u><br>DUE TO (c) <u>  </u> |                                   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>   |                                   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |                                   | 20f. (City or town) (County) (State) <u>  </u>  |   |
| 21. I certify that I attended the deceased from <u>June 1, 1967</u> to <u>Oct 14, 1967</u> , that I last saw the deceased alive on <u>Oct 13, 1967</u> , and that death occurred at <u>6:05 A.M.</u> from the causes and on the date stated above.   |                                   |   |   |
| ACTUAL SIGNATURE <u>Dr. Joseph P. Keurick</u>  |                                   | ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda, Md.</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Dr. JOSEPH P. KEURICK</u>   |                                   | DATE SIGNED <u>10/14/67</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>10-18-67</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Lewisburg, West Virginia</u>     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |                                   | 24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |
| DATE <u>OCT 18 1967</u>  |                                   | DATE <u>OCT 18 1967</u>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14178

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>1821 Powder Mill Rd.</u>   |   | d. STREET ADDRESS <u>1821 Powder Mill Road</u>  |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>Gladys</u> Middle <u>(NMN)</u> Last <u>PARKS</u>   |   | 4 DATE OF DEATH<br>Month <u>OCT</u> Day <u>7</u> Year <u>1967</u>   |   |
| 5 SEX <u>Fe</u>   | 6. COLOR OR RACE <u>Negro</u>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 14, 1925</u> 42 yrs   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTY SHOP OPERATOR</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country) <u>D.C.</u>   |
| 13 FATHER'S NAME <u>THOMAS BANKS</u>  |   | 14 MOTHER'S MAIDEN NAME <u>LORETTA MANNING</u>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>  |   | 16. SOCIAL SECURITY NO. <u>—</u>  | 17. INFORMANT <u>Mother</u> Address   |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute coronary thrombosis</u><br>DUE TO<br>(b) <u>Coronary artery heart disease</u><br>DUE TO<br>(c) <u>—</u>  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>BELOEN R. READ M.D.</u>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |   | 23b. DATE THEREOF <u>10-12-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat</u>                                       |
| 24. FUNERAL DIRECTOR <u>H S Wachtman &amp; Sons 4425 N. Ave (De ME)</u>   |   | 23d. LOCATION (City or town) (County) (State) <u>Baltimore Md</u>   |   |
| 25a. RECD BY REGISTRAR <u>Oct 16 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |   |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>b STATE <u>Md.</u> c COUNTY <u>Montgomery</u>                        |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |   | c LENGTH OF STAY IN 1b<br><u>D.O.A.</u>  |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital</u>   |   | d STREET ADDRESS<br><u>8505 Springvale Road</u>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>SAMUEL OSCAR PECK</u>  |   | 4 DATE OF DEATH<br>Month <u>10</u> - Day <u>14</u> Year <u>1967</u>  |   |
| 5 SEX<br><u>Male</u>  | 6 COLOR OR RACE<br><u>Cauc.</u>         | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>12-24-88</u> 78<br>9 AGE (in years and month) <u>78</u> y's |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Broker</u>   |   | 10b KIND OF BUSINESS OR INDUSTRY<br><u>Real Estate</u>   |   |
| 11 BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13 FATHER'S NAME<br><u>Hugh T. Peck</u>   |   | 14 MOTHER'S MAIDEN NAME<br><u>Charlton</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |   | 16 SOC. SEC. NO.<br><u>578-10-9449</u>   |   |
| 17 INFORMANT<br><u>(SON) Hugh T. Peck, Silver Spring</u>  |   | 18 ADDRESS<br><u>10511 DENEANE RD.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u><br>DUE TO (b) <u>Coronary Artery Heart Disease</u><br>DUE TO (c) <u></u>  |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |   |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |   | 20d INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>    |   |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><u>Belden R. Reap</u> M.D.  |   | 22. DATE SIGNED<br><u>10-14-1967</u>   |   |
| EXAMINER'S NAME (Type)<br><u>BELDEN R. REAP M.D.</u>  |   | Address (City or town) (County) (State)<br><u>Silver Spring, Md.</u>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b DATE THEREOF<br><u>Oct 17, 1967</u> | 23c NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>  | 23d LOCATION (City or town) (County) (State)<br><u>Suitland, Maryland</u>         |
| 24 FUNERAL DIRECTOR<br><u>Warner E. Humphrey, Inc.</u>  |   | 25a REC'D BY REG. STRAR<br><u>DA OCT 19 1967</u>   |   |
| 25b REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |  |   |



14175

## CERTIFICATE OF DEATH

14180

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |                                 | c. LENGTH OF STAY IN 1b<br><u>3 days</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>   |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lorine</u> Middle <u>Lillian</u> Last <u>Peterson</u>  |                                 | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>30</u> Year <u>1967</u>  |  |
| 5 SEX<br><u>Female</u>   | 6 COLOR OR RACE<br><u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>14 May 1907</u> |
| 9. AGE (In years last birthday)<br><u>60</u> yrs   |                                 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>--</u>   |                                 | 11. BIRTHPLACE (County & State or foreign country)<br><u>Illinois</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                 | 13. FATHER'S NAME<br><u>Jud Lair</u>   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Lillian Miller</u>  |                                 | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>                                       |  |
| 16. SOCIAL SECURITY NO.<br><u>360-28-8890</u>  |                                 | 17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO<br>(b) <u>Hypoxia and Pulmonary Bleeding</u><br>DUE TO<br>(c) <u>Endobronchial Amyloidosis</u>                                       |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u><br><u>2 hours</u><br><u>20 years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 | 19. WAS A T.O.P.S.Y. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (X) (this hospital) attended the deceased from <u>27 October</u> , 19 <u>67</u> , to <u>30 Oct.</u> , 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>30 October</u> 19 <u>67</u> , and that death occurred at <u>1:20 M</u> , from causes and on the date stated above. |                                 |  |  |
| 22a. SIGNATURE<br><u>Henry Benfer Kaltreider, M.D.</u> M.D.  |                                 | 22b. DATE SIGNED<br><u>Oct. 30, 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Henry Benfer Kaltreider, M.D.</u>   |                                 | 22d. ADDRESS<br><u>Institutes of Health, Bethesda, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  |                                 | 23b. DATE THEREOF<br><u>10-31-67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>   |                                 | 23d. LOCATION (City or Town) (County) (State)<br><u>Suitland Prince Georges</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Robert A Pumphrey</u>   |                                 | 25a. REC'D BY REGISTRAR<br><u>NOV 3 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>f Charles Judge</u>   |                                 |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-15. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14181

|  |   |  |  |
|--|---|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Damascus -</u>  |   | c. LENGTH OF STAY IN 1b<br><u>3 mo.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Route 2, Breckin Crumery Rd.</u>   |   | d. STREET ADDRESS<br><u>Route #2, Hawthorn Creamery Rd.</u>  |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>John James Petri</u>  |   | 4 DATE OF DEATH<br>Month <u>October</u> Day <u>5</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>M.</u>  | 6 COLOR OR RACE<br><u>W.</u>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>July 25, 1926</u>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><u>Production Foreman</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Electric Co -</u>  | 9 AGE (In years lost birthday)<br><u>41</u> yrs                            |
| 11 BIRTHPLACE (State or foreign country)<br><u>Mass.</u>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13 FATHER'S NAME<br><u>Frank P. Petri</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Margret C. Frank</u>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>010-20-7422</u>   |  |
| 17. INFORMANT<br><u>Wife</u>   |   | Address  |  |
| 18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u><br>DUE TO (b) <u>Cardio Vascular Disease -</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Several</u><br><u>years.</u>        |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE<br><u>John G. Ball</u>  |   | 22. DATE SIGNED<br><u>10/5/67</u>  |  |
| EXAMINER'S NAME (Type)<br><u>John G. Ball, M.D.</u>  |   | Address (Street, city, town, or county)<br><u>Bethesda, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>Oct. 9, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>South View</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>North Adams, Mass.</u> |
| 24 FUNERAL DIRECTOR<br>ADDRESS<br><u>Olin L. Molesworth, Damascus, Md.</u>   |   | 25a. REC'D BY REG. STR. DATE<br><u>OCT 9 1967</u>  |  |
|  |   | 25b. REG. DEPT. SIGNATURE<br><u>John G. Ball</u>   |  |

MEDICAL CERTIFICATION





## CERTIFICATE OF DEATH

|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WHEATON</u>   |   | c. LENGTH OF STAY IN 1b<br><u>8 DAYS</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>RANDOLPH HILLS NURSING HOME</u>   |   | d. STREET ADDRESS<br><u>3602 Kenway Street</u>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <u>FLORA</u> Middle <u>A.</u> Last <u>PETZOLD</u>   |   | 4 DATE OF DEATH<br>Month <u>OCT.</u> Day <u>12</u> Year <u>1967</u>   |   |
| 5 SEX<br><u>FEMALE</u>   | 6 COLOR OR RACE<br><u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>JAN. 9, 1899</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  | 9. AGE (In years lost birthday)<br><u>73 yrs</u>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Peoria, Illinois</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |   |
| 13. FATHER'S NAME<br><u>George Williams</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>M. Harms</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO.<br><u>yes</u> <u>220-44-2701</u>  |   |
| 17. INFORMANT<br><u>Richard Petzold</u>  |   | <u>9412 Russell Road</u><br><u>Silver Spring, Maryland</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY ARTERY OCCUSION</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>CORONARY ARTERY DISEASE</u><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>15 MIN.</u><br><u>3 YEARS</u>                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>ARTHRITIS, RHEUMATOID, ADVANCED, CHRONIC (2) Recent Peptic ulcer</u>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/11, 1964</u> , to <u>10/12, 1967</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>10/12, 1967</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><u>James A. Roberts</u> M.D.   |   | 22b. DATE SIGNED<br><u>OCT. 12, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JAMES A. ROBERTS M.D.</u>   |   | 22d. ADDRESS<br><u>8907 GEORGIA AVE. SILVER SPRING, MD.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>Oct. 14, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Rockville, Maryland</u>                       |
| 24. FUNERAL DIRECTOR'S NAME (Type)<br><u>Glenn Carter</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DATE OCT 19 1967</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   | 25c. ADDRESS<br><u>Glenn Carter 8434 Georgia Ave. Silver Spring, Md.</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



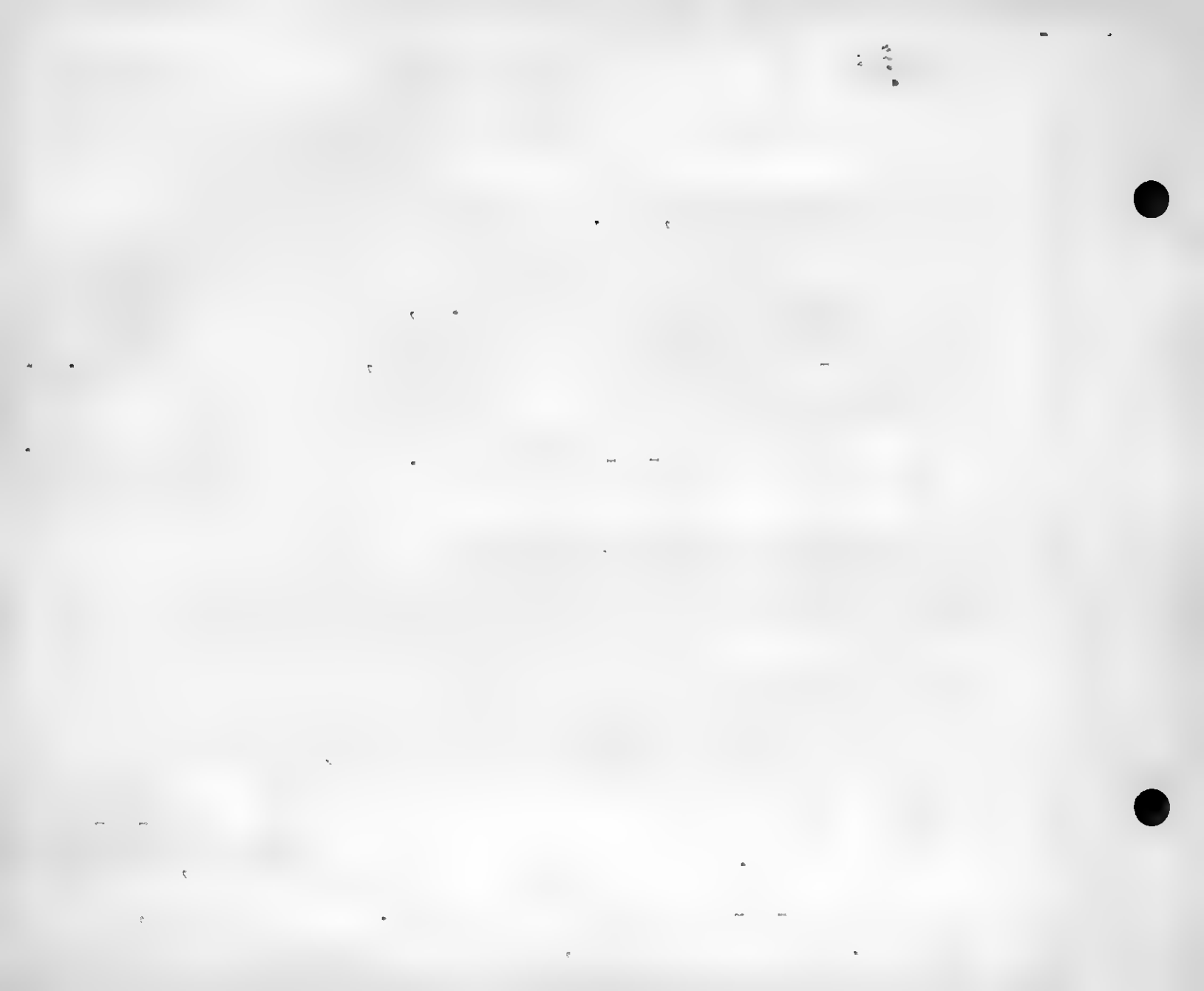
CERTIFICATE OF DEATH

14183

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institut. on Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 Year</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>10500 Rockville Pike, Apt. 415</b>   |                                  | e. STREET ADDRESS<br><b>10500 Rockville Pike</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>HERMAN JOSEPH PFUNDSTEIN</b>  |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>26</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 6, 1906</b> |
| 9. AGE (In years last birthday) yrs. <b>60</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>26</b> Days <b>19</b> Hours <b>67</b> Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman - Drug Fair</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Brooklyn, New York</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U. S.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |   |
| 13. FATHER'S NAME<br><b>Anthony Pfundstein</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Bayer</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>577-09-7136</b>   |   |
| 17. INFORMANT<br><b>Wife</b>  |                                  | Address<br><b>Same as Item 2.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b><br>DUE TO<br>(b) <b>Cardio-Vascular Disease -</b><br>DUE TO<br>(c) <b>Arterio-Sclerosis - Generalized -</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>Years.</b><br><b>Years.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (the hospital) attended the deceased from <b>1963</b> to <b>date</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>29 Sept</b> 1967, and that death occurred at <b>early AM</b> , from causes and on the date stated above.           |                                  |   |   |
| 22a. SIGNATURE<br><b>John S. Ball</b>   |                                  | 22b. DATE SIGNED<br><b>10-26-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN G. BALL</b>   |                                  | 22d. ADDRESS<br><b>7936 Old Georgetown Rd - Bethesda, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>10-30-67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Silver Spring, Maryland</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 30 1967</b>  |   |
|   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14178

14181

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b><br>c. LENGTH OF STAY IN 1b <b>43 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL MEDICAL CENTER</b>  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MOUNT AIRY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MOUNT AIRY</b><br>d. STREET ADDRESS <b>ROUTE #1</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Doris Marie</b> Middle <b>PONCE</b> Last <b>PONCE</b>   |  | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>30</b> Year <b>19 67</b>  |  |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>CAUC.</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>JUNE 28, 1930</b>  |
| 9. AGE (In years lost by birthday) <b>37</b> yrs   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.  | 11. IF UNDER 24 HRS  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11 BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>                     |
| 12 CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 13. FATHER'S NAME <b>EMMETT DOWNING BROWN</b>   |  |
| 14. MOTHER'S MAIDEN NAME <b>KEREN M. JONES</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |  |
| 16 SOCIAL SECURITY NO. <b>578 40 8079</b>  |  | 17. INFORMANT HUSBAND <b>HECTOR G. PONCE</b> Address <b>SAME AS # 2</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cloacogenic Squamous Cell Carcinoma of Rectum</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO<br>(c)  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS A TAPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT 19</b> , 19 <b>67</b> , to <b>30 OCT</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>OCTOBER 30</b> , 19 <b>67</b> , and that death occurred at <b>7:23 PM</b> , from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE <i>William R. Hix</i>   |  | 22b. DATE SIGNED <b>31 OCT 67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>William R. HIX, M. D.</b>  |  | 22d. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD.</b>   |  |
| 23a. BURIAL, CREMATION, <b>BURIAL</b> (Specify)  | 23b. DATE THEREOF <b>NOV. 2-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM.</b>   | 23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>                       |
| 24. FUNERAL DIRECTOR <b>COLLINS FUNERAL HOME, 3821 14th Street, NW</b>   |  | 25a. REC'D BY REGISTRAR <b>NOV 2 1967</b>   | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>  |
| ADDRESS <b>WASHINGTON, D. C.</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

14155

CERTIFICATE OF DEATH

|  |   |  |                                      |
|--|---|--|--------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u><br>MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br>b. COUNTY<br><u>Washington, DC</u>                      |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |   | c. LENGTH OF STAY IN 1b<br><u>93 days</u>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban Hospital</u>   |   | d. STREET ADDRESS<br><u>200 Rhode Island Ave. N.E.</u>   |                                      |
| 3 NAME OF DECEASED<br>(Type or print)<br><u>Bessie</u>   |   | 4 DATE OF DEATH<br>Month <u>Oct</u> Day <u>16</u> Year <u>1967</u>   |                                      |
| 5 SEX<br><u>Female</u>   | 6 COLOR OR RACE<br><u>white</u>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>12/27/12</u>   |
| 9 AGE (In years last birthday)<br><u>88</u> yrs.   |   | 10 IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>16</u> Hours <u>0</u> Min <u>0</u>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Food Checker</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Hotel</u>  |                                      |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>Virginia</u>  |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                                      |
| 13. FATHER'S NAME<br><u>Wallace Davis</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Janie Cook</u>  |                                      |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>579-10-0907A</u>   |                                      |
| 17. INFORMANT<br><u>Mrs. Janie White</u>   |   | Address<br><u>Wash., DC</u>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHO PNEUMONIA</u><br>DUE TO<br>(b) <u>COMPLICATIONS OF GASTRECTOMY</u><br>DUE TO<br>(c) <u>CARCINOMA STOMACH</u>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 DAYS</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>ATHEROSCLEROSIS GENERAL AND CEREBRAL</u>   |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 18</u> , 19 <u>67</u> , to <u>OCT. 16</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>OCT. 15</u> , 19 <u>67</u> , and that death occurred on <u>OCT. 16</u> , 19 <u>67</u> , from causes on and on the date stated above |   |  |                                      |
| 22a. SIGNATURE<br><u>Robert G. Angle</u>   |   | 22b. DATE SIGNED<br><u>OCT. 16, 1967</u>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)   |   | 22d. ADDRESS   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 23b. DATE THEREOF<br><u>10/18/67</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Bethel</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Alexandria, Va.</u>  |                                      |
| 24. FUNERAL DIRECTOR<br><u>Walter J. Noel</u>  |   | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>  |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   | DATE<br><u>OCT 17 1967</u>   |                                      |

CUNNINGHAM FUNERAL HOME ALEX. VA





CERTIFICATE OF DEATH

|  |  |   |   |
|--|--|---|---|
| 1 PLACE OF DEATH<br>a COUNTY <u>Montgomery</u> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)<br>a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>   |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c LENGTH OF STAY IN 1b <u>42 days</u>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |  | d STREET ADDRESS <u>6104 Stardust Lane</u>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>RESAMOND HUNT PRICE</u>   |  | 4 DATE OF DEATH<br>Month <u>October</u> Day <u>31</u> Year <u>1967</u>  |   |
| 5 SEX <u>female</u>  | 6 COLOR OR RACE <u>white</u>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  | 8 DATE OF BIRTH <u>6/22/13</u>                                    |
| 9 AGE (In years last birthday) <u>54 yrs</u>   |  | 10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed - housewife</u>   |   |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Bethesda - Maryland</u>  |  | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13 FATHER'S NAME <u>George Henry G. Hunt</u>   |  | 14 MOTHER'S MAIDEN NAME <u>Annand Harlow</u>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>  |  | 16 SOCIAL SECURITY NO <u>no</u>   |   |
| 17 INFORMANT <u>Charles John C. Hunt - 5225 West Parkway</u>   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u><br>DUE TO (b) <u></u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)  | 20f (City or town) (County) (State)                               |
| 21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 5th</u> , 19 <u>67</u> , to <u>10-31-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-31-</u> , 19 <u>67</u> , and that death occurred at <u>6:59 PM</u> , from causes and on the date stated above. |  |   |   |
| 22a SIGNATURE <u>Stephen W. Deiter</u>   |  | 22b DATE SIGNED <u>10/31/67</u>   |   |
| 22c PHYSICIAN'S NAME (Type) <u>STEPHEN W. DEITER, A.D.</u>   |  | 22d ADDRESS <u>6719 WILSON LANE, BETHESDA, MD 20814</u>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b DATE THEREOF <u>11-3-1967</u>  | 23c NAME OF CEMETERY OR CREMATORY <u>Rockville, Cemetery</u>  | 23d LOCATION (City or Town) (County) (State) <u>Rockville, Md</u> |
| 24 FUNERAL DIRECTOR<br><u>Joseph Gawler's Sons, Inc.</u><br><u>5130 Wisc. Ave. N.W. Wash.D.C.</u>  |  | 25a REC'D BY REGISTRAR<br>DATE <u>NOV 6 1967</u>  |   |
|  |  | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14182

CERTIFICATE OF DEATH

1-1187

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>MONTGOMERY</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <u>DC</u> b COUNTY <u>✓</u>                               |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>  |  | c LENGTH OF STAY IN 1b <u>16 days</u>  |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San &amp; Hosp</u>  |  | d. STREET ADDRESS <u>1411 Spring Rd., NW</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>BETHEL</u> First <u>NONE</u> Middle <u>PHILLIAM</u> Last   |  | 4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1967</u>  |  |
| 5 SEX <u>F</u>  | 6 COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-29-94</u> 9 AGE (n years lost birthday) <u>72</u> yrs   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S. W.F.</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>   |  | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>JAMES CRANTZ</u>   |  | 14. MOTHER'S MAIDEN NAME <u>JUDY UPDIKE</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO   |  |
| 17. INFORMANT <u>CHART</u>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO (b) <u>Hemorrhage</u><br>DUE TO (c) <u>Severe Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Congestive Heart Failure</u>  |  |  |  |
| 19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> o.m. p.m.  | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21 I certify that (I) (this hospital) attended the deceased from <u>January</u> , 1961, to <u>October 26</u> , 1967, that (I) (we) last saw the deceased alive on <u>October 25</u> , 1967, and that death occurred at <u>7:03 AM</u> , from causes and on the date stated above.   |  |  |  |
| 22a SIGNATURE <u>Stuart L. Nelson</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b DATE SIGNED <u>10-26-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>STUART L. NELSON</u>  |  | 22d. ADDRESS <u>University Blvd. E Silver Spring Md</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>Oct. 30, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Annapolis Pn. Geo. Co. Md</u> |
| 24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>2974 Gabriel Rd. Washington, D.C.</u>   |  | 25b REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 27 1967</u>  |  |



## CERTIFICATE OF DEATH

14183

14188

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|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Orney</b>   |   | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Montgomery General Hospital</b>   |   | d. STREET ADDRESS<br><b>111 Central Ave.</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Dora Estelle Purdum</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Oct. 8 19 67</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        | 8. DATE OF BIRTH<br><b>Feb. 17, 1899</b>                               |
| 9. AGE (In years lost birthday) yrs.<br><b>68</b>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Cedar Grove, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>James W. Johnson</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Emma C. Burdette</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>220-54-1122</b>  |  |
| 17. INFORMANT<br><b>Harry Lee Purdum,</b>  |   | Address<br><b>Item 2</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b><br>DUE TO <b>(Anterior)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Atherosclerosis - Gen'l - severe</b><br>DUE TO <b>(Cardiomegaly)</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>Years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)<br><b>Oct. 8 '67</b>              |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1949</b> to <b>Present</b> , that (I) <del>two</del> saw the deceased alive on <b>Oct. 1 1967</b> , and that death occurred at <b>5:00</b> M, from causes and on the date stated above.   |   |  |  |
| 22a. SIGNATURE<br><b>Jack Schumacher</b> M.D.  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED<br><b>10-9-67</b> |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jack Schumacher, M.D.</b>   |   | 22d. ADDRESS<br><b>105 Russell Ave., Gaithersburg, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Oct. 10, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rockville, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Olin L. Molesworth, Damascus, MD.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 13 1967</b>   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 18 Film G307 2/2/68

CERTIFICATE OF DEATH

14189

14184

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |   | c. LENGTH OF STAY IN 1b<br><b>2 Yrs. 9 Mos.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Potomac Valley Nursing Home</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>THOMAS Walter PYLE</b>  |   | 4. DATE OF DEATH<br><b>Oct. 9, 1967</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 7, 1888</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Asst. Supt. Public Schools - Retired</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   | 9. AGE (In years last birthday)<br><b>79 yrs.</b>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>William Stamp Pyle</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Price Hoopes</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW I</b>  |   | 16. SOCIAL SECURITY NO.<br><b>219-36-7682</b>   |  |
| 17. INFORMANT <b>Wife</b> Address<br><b>Helen D. Pyle Same as Item 2.</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO <b>Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis</b><br>(c) <b>Arteriosclerosis</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Oct 9 1967</b><br><b>Years</b>                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Barbiturate</b>   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19 to <b>Present</b> , 19 that (I) (we) last saw the deceased alive on <b>Oct 7</b> , 1967, and that death occurred at <b>7 P</b> M, from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>George Sharpe</b>  |   | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE SHARPE</b>  |   | 22d. ADDRESS<br><b>10400 Conn. Ave. Kensington, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>10-12-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Broad Creek Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hartford County, Md.</b>                   |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |   | 25a. REC'D BY REGISTRAR<br><b>OCT 16 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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